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Table of Contents.

SOME IDEALS FOR A PSYCHIATRIC SERVICE.[1]

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ONE of the main functions of this association is to improve the lot of the psychiatric patient, not only regarding individual treatment, but regarding the organization whereby treatment and after-care can be carried out under the best conditions available.

It may be presumption on my part to deal with a problem which has in the past been considered mainly departmental, as my own work has been carried on outside any mental hygiene department. The development of extra-institutional psychiatry has made such strides during the past twenty years that perhaps I may approach the subject of a national psychiatric service with an open mind, and perhaps with a sense of criticism of some of the present existing conditions together with, I hope, some suggestions of a more constructive nature. It may be of interest to trace this development of psychiatry as practised outside mental hygiene departments during this period.

In 1923 I was appointed to take charge of the first psychiatric department attached to a teaching hospital in Melbourne. At that time psychiatry was thought of mainly in terms of mental hospital work, though the 1914-1918 war brought home to the medical profession the fact that functional nervous disorders were being constantly seen in medical and surgical practice. The psychological approach was scarcely recognized as a respectable part of medical practice, the profession generally was vague as to how treatment could be carried out, and interest was mainly concerned in separating organic neurological diseases from functional states. The many patients attending out-patient departments, presenting symptoms for which no obvious organic basis could be found, were subjected to thorough and exhaustive physical investigations, and toxic foci, real or suppositious, were removed. If symptoms persisted, it was rather inferred that they were imaginary, and interest in the patient was lost. The psychiatric department was at first rather regarded as a dumping ground for those patients whose symptoms had become so established that they were resistant to ordinary medical treatment and as a last resort were referred for psychological investigation.

In course of time it was seen that the psychiatric clinic could be made use of as a diagnostic centre in cases in which there was some doubt concerning the physical origin of an illness, though the question of early treatment, especially in-patient treatment in a general hospital, was scarcely envisaged. The psychiatrist was still isolated from general medicine unless he dealt with neurological problems; his methods of treatment were regarded with suspicion or perhaps awe, and his language was a jargon to the general physician or surgeon. The psychiatrist was often at fault and tended perhaps to encourage this aloofness, to the detriment of psychiatry and general medicine.

Neurology was the link that held psychiatry in relation to general medicine, and perhaps we lose something by not calling ourselves neuropsychiatrists; there are many problems, such as head injuries, cerebral tumours and neurosyphilis, whose interests are common to neurology and psychiatry. Modern psychiatry has now expanded to embrace many aspects of social medicine which are outside the realms of pure neurology, but every effort must be made to bridge the gap that there has been in the past between psychiatry and general medicine.

In this State of New South Wales the development of clinics and extra psychiatric beds is exemplified by the

[1] Read at a meeting of the Australasian Association of Psychiatrists held on October 22 and 23, 1947, at Sydney.

magnificent psychiatric block at the Royal Prince Alfred Hospital and by Broughton Hall.

The teaching hospitals in all States now have their psychiatric departments, and the development and organization of the medical and non-medical personnel is gradually taking place. The new Royal Melbourne Hospital has a psychiatric ward of 30 beds as part of the psychiatric department.

The development of these clinics has undoubtedly brought psychiatry into closer relationship with general medicine, stimulated the student's interest in psychological problems, and given the public an opportunity to seek early psychiatric advice. Psychiatric opinion is now asked for in general medical and surgical wards of the teaching hospitals and guidance sought regarding treatment of psychosomatic disorders.

Modern physical methods of treatment have become more or less popularized, perhaps to a somewhat dangerous extent, as the psychiatrist is beginning to be shorn of his aura of mystery and is regarded by some as a robot whose therapy consists of pressing the button of an electric convulsive machine or of giving large doses of insulin in order to produce a state of coma. Surgical aid is now sought to perform an operation which may alter the patient's pattern of behaviour. The word "shock" as a prefix to treatment either arouses a sense of horror or fear in the public mind or causes the sufferer from an emotional disorder to seek "shock treatment" blindly as a method of escape from distressing symptoms. Let it be said here to you who are unversed in psychiatry that these physical methods of treatment are mere adjuncts, though useful and important adjuncts, in the treatment of psychiatric problems.

Let us consider the relationship between psychiatry as practised outside and inside mental hygiene departments.

The out-patient psychiatric clinics were originally intended for subjects of neuroses and "borderline" patients, whereas the mental hospitals were regarded as being exclusively for the psychotic who may be difficult to manage in a general hospital. It was not grasped that the psychotic rarely manifests acute symptoms or antisocial behaviour without some preliminary less acute manifestations. It may be, and very often is, extremely difficult without adequate observation to state whether the patient is going to recover completely, to be liable to recurrent episodes or eventually to fall into the class of the chronic insane. It may be even difficult at first sight to decide whether a patient showing an emotional disorder is suffering from a neurosis or an early psychosis. Thus the psychiatric out-patient clinics do cater for nearly all forms of mental illness, at least from the investigatory standpoint.

In less enlightened days the relatives of the mentally sick would often refuse to face the facts of a mental illness, fearing the stigma of insanity and certification to a mental hospital. Many of these patients thus were subsequently forced to go into hospital at a stage when recovery was difficult. The public are, however, now becoming imbued with the knowledge that early treatment is essential for a good recovery rate.

The admission of patients to mental hospitals under the voluntary system relieved to some extent anxiety concerning the necessity for certification, but there is still the public's prejudice against mental hospitals, which is likely to remain until governments are willing to spend more money on improvements and expansion. The practice of psychiatry in the mental hygiene departments has made very great advances during the past generation, and it is for this association to urge that the conditions under which psychiatrists are working in these departments should be brought into line with modern thought and requirements. There should be a complete correlation between these departments and outside organizations in a properly coordinated mental health service.

I am indebted to the memorandum prepared jointly by the Royal College of Physicians in London, the British Medical Association's group of practitioners in psychological medicine, and the Royal Medico-Psychological Association in Great Britain for the diagram (see Figure I) that you have before you, as well as for the general ideas concerning a national psychiatric service.

In the sparsely populated areas in Australia conditions of such a service must be modified; also the different State laws regarding certification may present certain difficulties in forming a uniform national psychiatric service throughout Australia.

The correlation of the psychiatric resources of a country does not necessitate unification of control, though undoubtedly some coordinating factors would be helpful.

Mental hospitals, because of their legal responsibilities and immense organization, must be under some Government control and authority. In the past this has led to a certain degree of isolation of those working within the Government department from outside medical practice.

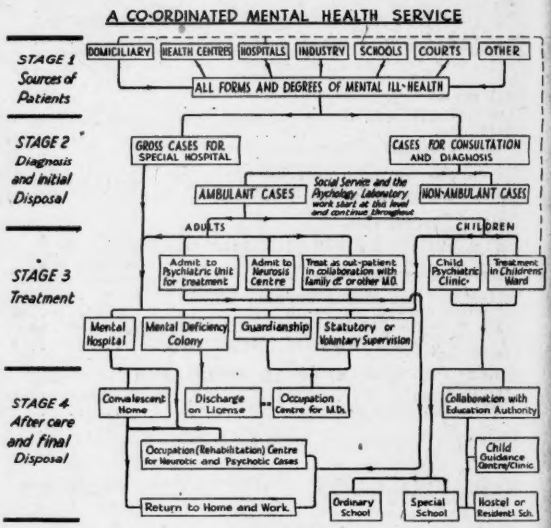

FIGURE I.

The formation of the Association of Psychiatrists, consisting to a large extent of mental hygiene department psychiatrists, is ample evidence of the breaking away from this isolation.

Although the psychiatric departments attached to teaching hospitals are primarily for the benefit of the hospitals and are responsible to the committees of management of their respective hospitals, there is no reason why these units should not be brought into closer contact with the mental hospital services.

In any scheme envisaging a psychiatric service as a whole there should be some directing influence. There is no suggestion of regimentation or bureaucratic control, though a mental health service should fit in with any properly organized scheme for the nationalization of medicine, if such is to be.

The essence of such a service should not only be for the lower earning groups, but one where facilities can be made available to all. The private practitioner would not surrender his rights to treat his own patients, but he will be able to make use of the resources of this service, in which there should be complete collaboration between medical and non-medical workers, whether their sphere of work is inside or outside mental hygiene departments.

It has been recommended in the White Paper on Health Services in Great Britain that provision for mental health in all its aspects should be the responsibility of the joint health authorities.

It is feasible that a psychiatric board might be appointed in each State, consisting of representatives from medical, legal, nursing, educational, administrative and architectural authorities. Such a body would advise the governments and coordinate the activities of such a service. This

would allow the directors of mental hygiene to give their valuable time to directing the professional side of their departments.

This board could supervise propaganda when necessary and would obviate the present state of affairs, which does not permit medical officers working in the mental hygiene departments to criticize the working of their own departments.

The councils for mental hygiene made an attempt to carry out many of these functions; these were not, however, entirely expert bodies and they did not possess the authority or financial backing to bring about any drastic changes, though the councils in each State have done extremely useful work in the past.

There are four stages in the career of a psychiatric casualty.

The first stage is at the source from which these casualties are drawn, the home, health centres, hospitals, industry, schools, courts *et cetera*. At present there is a haphazard distribution from these sources, and patients in the early period of their illness are liable to drift before they come under psychiatric care, thus losing valuable time when early treatment may be essential.

The second stage is that at which a tentative diagnosis and initial disposal should take place. The psychiatric out-patient clinic for ambulant patients is the ideal situation at which this second stage should take place, except in the case of acute or gross conditions, when the patient may be sent straight to the mental hospital or receiving house. There should be some system whereby a social worker under medical direction should guide the patient to a psychiatric clinic without delay.

The third stage is the remedial stage, in which in-patient or out-patient treatment is undertaken, and the fourth stage that in which after-care and final disposal take place.

In this scheme the psychiatric out-patient clinic feeds the various units of the system and, as such, must work in close cooperation with these units. Especially is this so in regard to after-care, when the patient who is discharged from hospital or rehabilitation centre should be kept under periodic observation in the out-patient department.

This must necessarily mean a great increase in out-patient doctor sessions per week.

The present system, whereby each teaching hospital's out-patient clinics have two half-day sessions per week, does not supply the necessary doctor-hour sessions to cope with the number of patients who should be investigated at these clinics. The establishment of more clinics may be necessary, as the teaching hospital out-patient departments are unable to cater for more than two sessions per week for any specialty. It is doubtful whether an out-patient department attached to a mental hospital is desirable, though the mental hygiene departments might establish clinics at easily accessible situations, whether in the city, suburbs or country centres. Clinics such as these could be staffed by mental hygiene department psychiatrists as well as by those working outside the departments.

In England the Ministry of Health sponsored a survey of the psychiatric clinics in England and Wales; this was undertaken by Dr. C. P. Blacker, who has published his results in book form, "Neurosis and the Mental Health Services", published in 1944.

At that time there were over 200 psychiatric clinics, exclusive of child guidance clinics, in England and Wales. Although these clinics are labelled "neurosis clinics", they are really the collecting centres for all types of psychiatric problems. These clinics are attached to non-teaching and provincial hospitals as well as to the teaching hospitals.

In Australia there are very few psychiatric clinics outside the teaching hospitals and Repatriation Department centres in each State. There is a need in provincial centres for the provision of psychiatric clinics, especially in districts where country mental hospitals are established, and where the medical officers working in these institutions could act as consultants to the clinics.

Blacker in his survey pointed out the great usefulness of psychiatric beds attached to the teaching clinics for the training of students and nurses, and he has suggested that there should be 100 psychiatric beds outside mental hospitals (not including private licensed houses) per million of population.

In Melbourne, with a population of well over a million, there is only one psychiatric ward of 30 beds outside the hospitals of the Department of Mental Hygiene and the Repatriation Department psychiatric ward at Heidelberg, and it is to be remembered that these beds serve the whole of Victoria, with a population of nearly two million. This does not include private hospitals where treatment is being carried out under more or less supervision of health authorities but not under any official psychiatric control.

There have been recent Press and public outcries in New South Wales and Victoria regarding overcrowding, lack of segregation and poor housing conditions in certain of the public mental hospitals.

Nobody can deny that such conditions exist, through no fault of any individual connected with the mental hygiene departments, but through lack of Government foresight in the past in failing to keep pace with the growing population and through the present unfortunate position regarding nursing shortage. The insulin treatment ward at Mont Park has had to be closed because of this shortage. The public should, however, realize the magnificent and heroic work that is being performed by medical and nursing staff, often under trying and difficult conditions.

There is no doubt that the deficiencies in the mental hospitals have brought about a good deal of diffidence on the part of the public to enter a mental hospital. Thus non-institutional beds are very much sought after and there are long waiting lists for these beds. Many patients will prefer to wait until there is a vacancy, though their illness may be progressing with often tragic results. These patients will often pay higher fees than they can afford to enter a private hospital in order to avoid admission to a public mental hospital.

Many of the private hospitals for treating psychiatric patients must come under review, for although a number of them are well organized, there is a tendency in some to be slipshod because of the great demand for beds. These hospitals should all be part of the mental health service, though for supervision purposes only. I refer not only to private licensed houses, but to hospitals which cater solely for nervous disorders of the milder type and to some convalescent homes for the aged and infirm.

Propaganda of the right kind would help to bring about reforms, and education of the public would eventually overcome public prejudice against admission to a mental hospital. This has been amply illustrated by Dr. Thomas Beaton, of Saint James's Hospital for Nervous Diseases at Portsmouth.

Dr. Beaton has formed a mental treatment centre at Portsmouth with close liaison with social services, public health authorities, education departments, magistrates' courts and all organizations connected with public welfare.

This centre consists of an out-patient department without any beds attached. Dr. Beaton and his colleagues have, by means of personal public propaganda, overcome public prejudice to such an extent that there is no hesitation in entering one of the Portsmouth mental hospitals; moreover, it is rare for a patient entering one of the mental hospitals to be certified.

This is an ideal situation for a provincial centre without a teaching clinical school, but it does not do away with the necessity for extra-institutional psychiatric beds in the larger areas, especially where there is a medical school.

There is ample scope in the larger capital cities in Australia for a hospital of, say, 100 beds which would be on a paying, intermediate and non-paying basis. This hospital should not be under the Mental Hygiene Department, but should be included in the mental health service. From a teaching point of view the type of case should be as much as possible selected from the point of view of post-graduate needs. The visiting and consultant staff of such a hospital would consist of recognized psychiatrists

of consultant rank, from both inside and outside the mental hygiene department. The resident staff would be composed of men who have already had some training in psychiatry, and would be a stepping stone to consultant psychiatric practice.

This hospital might be financed by the Government, and no doubt with an organized propaganda campaign would be endowed by private individuals, especially if laboratories for psychological and physical research in mental disorders were part of the hospital equipment. I have little doubt that the paying part of the hospital would offset to some extent the financial loss in the non-paying and intermediate beds. It has been shown that states of mild psychotic depression can be treated in general private hospitals, preferably in single bed units. A small psychiatric block should be attached to the newer type of intermediate hospital.

I do not propose in this address to deal with child psychiatry to any extent. This most important preventive branch of psychiatry fits into the scheme of a coordinated mental health service and should be the subject for some future discussion. There should certainly be an efficient follow-up system, whereby the problem child should in adult life be guided regarding vocation and should be given appropriate treatment when necessary in an adult psychiatric clinic. The plan shows the different stages whereby investigation, treatment and after-care or disposal can be carried out.

Apart from the organization of any psychiatric service, the first essential is to have sufficient and efficient trained personnel, medical and non-medical, to man it.

Sir Alan Newton, in his recent Stawell Oration, stressed the importance of unanimity of purpose and teaching in the various teaching hospitals of a medical school, welding them into one school instead of scattered independent units. This unanimity should apply in every way to the various psychiatric units composing the coordinated service; even though each unit may be under its own management, it should be an integral part of the medical school as well as part of a national service.

There is a need for more trained psychiatrists and a better appreciation of psychiatric problems amongst the medical profession generally. It may be some time before the inadequate teaching of undergraduates in the past can be overtaken. In the meantime there are very efficient psychiatrists in each State, many of whom are working within their respective mental hygiene departments. These men are overworked and a great deal of routine and administrative work is being carried out by psychiatrists whose special knowledge and talents could be put to better use as teachers and research workers. Departmental psychiatrists should also be given every opportunity to work in clinics outside their departments. It is a purpose of this association to encourage medical graduates whose interests lie in psychiatry to take higher degrees and diplomas and to fit themselves for what might be termed "consultant rank" in psychiatry. This applies to psychiatrists working both inside and outside mental hygiene departments. The excellent suggestion made by the Royal College of Physicians, that there should be junior resident posts at the metropolitan mental hospitals, should be carried out in Australia. These posts are tenable for a year and are primarily for graduates who are anxious to gain special knowledge in psychiatry as part of their medical training. No doubt some of these men would remain with the department and be absorbed in the service; others would go out into practice and be the better physicians or surgeons for their experience.

The psychiatrist of the future who is to attain consultant rank should be also a trained physician and should be given opportunity to take his higher medical degrees, the doctorate of medicine and membership of the Royal Australasian College of Physicians.

In order to maintain the efficiency of a psychiatric health service and to keep it up to date with other parts of the world, there should be a system whereby some of the more outstanding men should go abroad on full pay and at the expense of the health authorities.

This association is Australasian-wide; we should sponsor a system of exchange between various State mental hygiene departments and include, if possible, New Zealand mental hospitals, so that suitable medical officers from the less populated States or from outlying provincial mental hospitals should be given opportunities to work in or near teaching centres and to attend post-graduate courses not only in their departmental hospitals, but in the psychiatric clinics, with a view to taking higher degrees. These men on returning to their own States would be stimulated to found post-graduate courses, to the benefit of general practitioners in their respective States.

Research in neuropathology and psychopathology, as well as in clinical psychiatry, should be encouraged by scholarship grants and laboratory facilities.

It is not within the scope of this address to discuss the question of payment of salaried officers, but for any service to attract suitable medical recruits in sufficient numbers, those who by merit attain what we might call "consultant" rank should receive an income commensurate with that of their colleagues in private practice.

If this service was made sufficiently attractive, I have no doubt that, with the growing interest in psychiatry by younger medical graduates, there would be an ample supply of medical personnel for the needs of such a service.

One of the crying needs in all medical and health services is the present shortage of trained nursing staff. There should be a campaign to make an attractive career for a woman or a man who wishes to nurse psychiatric patients. It would be a benefit to nursing generally if the status of the mentally trained nurse was brought to the same level as the nurse who does her general training; there are hospital-trained nurses who are interested in this branch of medicine, especially those who have seen the results of modern physical methods and treatment. One feels that if the career was made sufficiently attractive regarding pay, housing, recreation and holidays, there would be no lack of applicants for the work.

This association has made plans whereby a psychiatric diploma in nursing can be gained by a nurse who has done her general training. This is to be carried out with the approval of the Royal Victorian Trained Nurses' Association and Nursing Board in Victoria.

A post-graduate syllabus of lectures and tutorials at recognized psychiatric hospitals and wards is being arranged and a course for this diploma should commence early next year.

There should be a regular exchange of nurses between mental and general hospitals, so that the mentally trained nurse will have an opportunity for doing her general training.

There is a large body of essential non-medical workers who function throughout the various stages of psychiatric treatment and investigation. The recent war has demonstrated to psychiatrists the very great importance of the psychologist in elucidating many of the problems in psychological medicine. There was perhaps a time when a certain amount of mutual suspicion and distrust existed between the psychiatrist and the psychologist. The important and essential work performed by the army psychologists has dispelled all thoughts of antagonism and the psychiatrist is coming more and more to rely on the investigations of the psychologist as a guide to treatment and rehabilitation of a patient. Rorschach tests in expert hands give psychiatrists valuable diagnostic information.

This community is fortunate in having courses for trained social workers and almoners. A certain number of trained social workers have done post-graduate work in England and America and have returned to Australia as psychiatric social workers. There is a need for many more such people, who should be employed in every branch of a psychiatric service, not only in the larger cities, but in the provincial districts.

Occupational therapy should be undertaken at various stages; from a therapeutic point of view in the early treatment stages, and in the rehabilitation stage when

occupation is encouraged to fit the patient for life outside. This is seen at its best in army and repatriation departments, inaugurated by the Australian Red Cross Society, and has served a most useful purpose in preparing the psychiatric casualties of war for civilian life. There are an insufficient number of occupational therapists at present, but training courses have been established.

Speech therapy plays an important part in the treatment of certain patients, and the speech therapy department is not only attached to the psychiatric clinic at the Children's Hospital in Melbourne, but also to the psychiatric department at the Royal Melbourne Hospital.

The stage of after-care and final disposal cannot be passed by without reference to the establishment of farm colonies for the long-term psychotic and psychopath who is unable to fit into the society of his fellow men. Mental hospitals in all States have farm lands where patients are able to work under supervision and are often able to take a certain amount of responsibility. There is need for the further development of these colonies for treatment and rehabilitation of the less established type of psychotic.

Under the present system of mental health there is very little provision for senile dementia. One sees on all sides families crippling themselves financially and endangering the domestic happiness in order to keep an aged parent from being certified and ending his or her life in a mental hospital. There should certainly be more provision in a mental health service for patients presenting a problem of this type, preferably outside the precincts of a mental hospital, or at least in some position of the grounds devoted solely for this purpose. In view of the results obtained by the operation of frontal leucotomy, an adequate operating theatre should be established at one of the mental hospitals.

There is a need for some amendments regarding psychiatry and legal restraint. The voluntary boarder system does allow a patient to seek treatment in a psychiatric hospital, and this is made use of to a very large extent in private licensed houses. There is, however, an understandable hesitation on the part of the mental hospital authorities to admit a patient under the voluntary system unless there is a complete understanding and willingness on the part of the patient to undergo treatment.

There are many patients who in the acute stage of a mental illness are incapable of making a decision regarding their treatment. There is a reluctance in Victoria for the relatives of a patient to allow certification, firstly because of the so-called stigma attached to certification, and secondly because certification implies that the patient's financial affairs are administered by the Public Trustee. In some cases this entails a good deal of difficulty, especially in cases in which there is a partnership or some family business which may be disrupted by outside interference, even though the intentions may be directed primarily for the benefit of the patient's estate.

It is found in private practice that certification is very seldom resorted to if recovery is possible, and I have always found a patient grateful afterwards for his not having been certified, though at the time of treatment he may have been difficult and recalcitrant.

On the other hand, there are certain psychopathic states which do not strictly come under the *Lunacy Act*, yet the subjects of them should be under legal restraint; under present circumstances it is difficult to restrain them, except by means of somewhat complicated legal machinery. I refer to subjects of chronic alcoholism and drug addiction, sexual offenders, and certain types of psychopathic social misfits. There are, unfortunately, insufficient facilities in the mental hygiene departments for the treatment and rehabilitation of these patients.

One would like to see some uniformity throughout Australia regarding these legal aspects of psychiatry.

Perhaps a few words would not be out of place regarding the housing and amenities for patients who may have to be in a mental hospital for a considerable period.

A long time may elapse before any large rebuilding scheme can be contemplated. There is no reason, however, with competent architectural advice, why some of our buildings should not be improved in outward appearance and in interior decoration with the expenditure of a moderate sum of money. Perhaps one of the simplest ways of gaining public confidence in a mental hospital is to have comfortable and tastefully furnished reception rooms, where a relative can interview patients and doctors.

Those who have to treat the chronic and deteriorated insane realize that the patient is indifferent to surroundings. This, however, is not so with the patient who is convalescing or who is in touch with his surroundings, nor with the people who have to care for the patient.

The mental hospital auxiliaries have done a great deal to ameliorate the condition of patients in mental hospitals, and in Melbourne have established an after-care convalescent home. These auxiliaries contain extremely helpful voluntary workers and should be encouraged; beware, however, of the well-meaning but unknowledgeable sentimentalist who takes every opportunity to undermine public opinion regarding mental health departments.

One of the amenities that should be carefully considered in a scheme for mental health is the question of diet. It is admittedly extremely difficult to cater for the varying types of patient in a large mental hospital. There is no doubt that proper segregation, especially regarding dining facilities, could overcome some of these difficulties. The appointment of a trained dietitian to every mental hospital would help to overcome the present dietetic deficiencies.

I have brought before your notice the outlines of a scheme whereby a coordination of effort on the part of psychiatrists and those interested in psychiatry may bring about a service which will not only serve the psychiatric needs of the community, but will act as a link between general medicine, psychiatry and social welfare.

It may be said, with perhaps some justification, that the availability of such a service to the community may pander to the neurotic and tend to produce a nation of dependants. There is a tendency for modern society to seek something for nothing, but the essence of any properly constituted health service must be to restore the dependant to a state of independency in the quickest possible manner. It rests upon the judgement and ability of the psychiatrist, together with the valuable aid of the psychologist, industrial officer and social worker, to decide to what extent a psychiatric casualty can be returned to a normal and useful community life. The occupational therapist and again the social worker play their important part in this restoration. I would be chary of offering any medical service such as this to the public without some *quid pro quo*. Every part of the service should be paid for according to the patient's means. Expenditure of public money (and a great deal would have to be spent for the service to be efficient) would return dividends, not so much in the money sense, but in the economy of man and woman power.

In England during the latter part of the war absenteeism from industry was largely caused through neuroses. Investigation proved that air raids and terrors which the people were experiencing had very little to do with the apparent increase of the neuroses. The armed services had eliminated those who were maladjusted and presented psychiatric problems, and they had been thrown into industry, thereby causing this increase in absenteeism.

The psychiatrists of the Emergency Medical Service, even in the rush of war-time emergency, were able to place these psychiatric casualties in occupations suited to their particular form of maladjustment, so that the wheels of industry were able to run smoothly.

Peace-time presents, perhaps, a different type of problem regarding industry and social welfare. There is a tendency to demand shorter hours of work with a correspondingly greater time for leisure.

Are we as psychiatrists, in a scheme for national service, prepared to lead the way in demonstrating that the leisure from the monotony of everyday work can be used to the greatest benefit to the individual and to the community?

Modern psychiatry has its many facets which impinge on all branches of medicine and all branches of social life. We should not set ourselves up as esoteric specialists,

but as medical men who are anxious to learn and willing to help in any scheme for the betterment of our race.

May I quote my great-uncle Henry Maudsley, who wrote these words in 1883:

Obviously this is not the best of all possible worlds since men have conceived a better in the Shape of Paradise, nor is it the worst of all possible worlds since they have conceived a worse in the Shape of a Hell. . . . Visions of Golden Ages of extinction of wars and other calamities, or reigns of righteousness and universal brotherhood, and the like are evolved as excellent ideals to inspire and guide the units in their struggles. If the prevalence of ease, luxury and self-indulgence be so great in a nation as to threaten its speedy decadence, an unforeseen reaction may occur suddenly and issue in the revival of austerity and asceticism and so pessimism gives place to idealism, for the reformer is the proper product of Evil times.

These words might have been written in the world as it is today. Are we as psychiatrists prepared to further the visions, perhaps not of the golden age, but of the reigns of righteousness and brotherhood, and pioneer a service in which the pessimism of the past may give place to the idealism of the future.

ALCOHOLICS ANONYMOUS.[1]

By S. J. MINOGUE,
Sydney.

> Who is weak, and I am not weak? . . . If I must needs glory, I will glory of the things which concern mine infirmities. (II Corinthians, II: 29-30.)
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> The very perfection of man is a knowledge of his own imperfections. (Saint Augustine, fifth century.)

ALCOHOLICS ANONYMOUS is the name given to an association of ex-inebriates. It is a movement aimed at keeping an alcoholic from drinking. It has no organization, no paid officers, no membership dues and no money. Any current expenses are met by secret collections at meetings. All offers of financial assistance are refused. Anyone who regards drink as his problem is free to join. As a body Alcoholics Anonymous takes no side in any controversial subject, such as temperance or prohibition. It is strictly non-political and non-sectarian. It has one object and one object only, that is, to keep the alcoholic sober.

The movement was founded in 1934 by Bill Wilson in America. At the time, although a successful business man, he was in danger of financial and social ruin as the result of his periodic sprees. Although he was desperately anxious to get well and underwent treatment by leading psychiatrists, the bouts continued. In 1934 he was told by a leading psychiatrist that the only cases of recovery of which he had known were in those who had had a "spiritual experience". Bill then joined the Oxford Group Movement and remained sober for six months. Then, beset with business difficulties and terrified lest he should seek oblivion in alcohol, he tried to forget his temptation to drink by attending to the wants of a doctor inebriate who was in the midst of a spree. In helping his patient he himself lost all desire to drink. Thus was discovered almost accidentally that the best way for an inebriate to keep sober is to help other inebriates. In helping others he forgets his own desire to drink.

The two of them then decided to help other inebriates. Progress was extremely slow. They met with, as we did in Sydney, hostility, ridicule, suspicion and sneers. Many joined them to get what they could from the other members. There was a daily crop of new anxieties, worries and difficulties. At the end of one year they had five members; after two years, 15; after three, 40; after four, 150. In 1939, when the membership was 400, they published their book "Alcoholics Anonymous", which gave the combined experience of all the members and enumerated the twelve steps which, if sincerely followed, would enable the inebriate to keep sober. The book, written by alcoholics for alcoholics, gives, probably for the first time, a true picture of the mind of the alcoholic, not the picture he presents to doctors and psychiatrists.

The movement spread rapidly from the United States to Canada and then to Hawaii. The first non-American branch was formed in Sydney in October, 1944. The establishment of this branch proved to be exceedingly difficult. Opposition, sneers and difficulties were our daily burdens. New trials and anxieties were met with every day. In the beginning all the members at times went "on the booze" together. New members would successfully tempt older members to get drunk with them. Those we expected to get drunk remained sober; others we expected to do well fell by the wayside. Only very occasionally during the first two years did we find a man who was sincerely desirous of remaining sober.

Eventually I was forced to realize that my enthusiasm had overcome my common sense and that my previous experience of inebriates was of very little help to me. I then came to the conclusion that if I was to know the mind of the inebriate (and know it I must if I am to treat him successfully) I would have to abandon my previous concepts and set out to learn the subject anew. To do this I took all inebriates I met at their face value and watched their clinical progress. It is only now, after three years of intensive experience, that I feel I have developed clinical acumen in the disease and feel confident of my prognoses.

It took two years for the Sydney branch to find its feet. Now there are ten branches in the city and suburbs, with further branches in the process of being formed in other States. As the result of very favourable publicity, the establishment of the movement in most parts of the Empire, its acceptance in medical literature and the excellent clinical results being obtained, alcoholics either seek the help of the movement themselves or they are advised to do so by an increasing number of doctors. The movement is rapidly becoming a world-wide one, with over 50,000 members, of whom over 200 are to be found in Sydney.

Alcoholics Anonymous is a spiritual movement based on religion of the broadest possible type. The patient must sincerely and honestly admit that his drinking has got out of control and that his life has become disordered. He must then believe that only a power higher than himself "can restore him to sanity". If he is a member of an orthodox religion he must go back to the practice of that religion. If he is an atheist or agnostic he must believe in his own concept of a higher power. It may be a strict adherence to such ethical principles as truth and honesty or even loyalty to Alcoholics Anonymous. But whatever the power may be, unless he adheres to its principles and appeals to it for help when tempted to drink, he will not remain sober.

The very fact that the patient admits he is powerless to control his drinking is the first sign that he is learning humility, which he must learn if he is to recover. For many years he has been arrogant and proud, "rushing through life like a tornado", fighting a one-man battle with the world, a pathological liar, deceiving doctors, psychiatrists and relatives. He has been a law unto himself, thinking that the world existed for his benefit alone. Because others would not take him at his face value, he became full of resentment and self-pity. At times, realizing that he would have to give up drinking, he would remain sober for months at a time, simply to prove to himself and others that he had his drinking under perfect control and "could give it away at any time". Oftentimes, maybe to satisfy relatives or employers, he sought psychiatric help, but told the psychiatrist a pack of lies. After his bouts, when intensely depressed and thinking of suicide, he swore he would never touch alcohol again, but, perhaps within a few hours of his leaving hospital, he was drinking as much as ever. Despite the fact that at times he had submitted himself to prolonged psychological or even shock treatment, the bouts continued. Always he had an excuse for his drinkng: domestic,

[1] Read at a meeting of the Australasian Association of Psychiatrists held on October 22 and 23, 1947, at Sydney.

financial and other worries. The excuse had to be good enough to satisfy himself and others.

A time came, generally at the end of a bout, but rarely before the age of thirty-five years, when he was forced to face stark reality for the first time. Faced with financial or domestic disaster, all his excuses for drinking were now useless. If he kept on drinking, ruination and death were inevitable. He had tried repeatedly in the past to reform, but had failed. He could not do so now without help, but where could he get it? He had repeatedly consulted doctors and clergymen in the past, but all he had received from them was the advice to be a man, realize his responsibilities and give up drinking. Psychiatrists had given him expensive treatments and at the end of them had told him not to drink. "God knows I tried hard enough, but failed." He had no confidence in anyone. Who had ever suffered like he was suffering? Who could understand his dreadful fears and apprehensions, his frightful imaginings? Had he not repeatedly twitted psychiatrists and clergymen with the fact that, whilst they had treated numerous alcoholics in the past, their successes had been so few and far between? He no longer wanted to be "talked down to". All that he wanted was someone to give him at least the glimmer of hope that his case was not hopeless.

The precise fact that Alcoholics Anonymous can give him this hope at the very moment he needs it most is the explanation of its astounding success in the management of a disease whose treatment up to the present time has been more or less hopeless.

He may have heard of Alcoholics Anonymous months or years before and, although he may have scoffed at the idea, he has nevertheless kept their telephone or box office number at the back of his mind, to be used when all else had failed.

Relatives, on their own initiative or on the advice of doctors, asked Alcoholics Anonymous members to visit him. In the early days of the movement it was almost impossible to find a member of his own profession or walk in life. As the numbers grew, an astute secretary could find a man "who would click with him".

He finds at his bedside one or two clear-skinned, well-dressed men whom he may have once known as fellow drinkers. They tell him the story of their own life and drinking habits. Because their stories parallel his own he has confidence in them. They tell him how they found salvation in Alcoholics Anonymous and, if he wishes to do the same, they are willing to help him. All that they ask from him in return is a sincere desire to give up drinking. Bitter experience has convinced them of the futility of trying to convince him against his will. They simply point out what Alcoholics Anonymous has to offer, and it is up to him to refuse or accept that offer. It is useless for him to try to deceive them. They are not to be deceived by lies and tricks they once used themselves. They leave with the promise that they will return at any time he feels that he needs their help.

Many of the patients are frigidly polite. They thank the callers for coming and do no more about it. They are usually of the type who have as yet suffered little for their drinking and think they have it under control. Some of these appeal for help months or years later. Others are impressed, but, as they expect to recover within a few days, and as they know their wives and relatives will forgive them, they are not sincerely anxious to recover. Only when a patient is desperately anxious to get well does he sincerely listen to the message being given to him.

After having been "dried out", perhaps in hospital, he is taught the twelve steps of Alcoholics Anonymous. It is impressed upon him that he must be sincere and honest and examine his past life fearlessly and honestly. He should make a list of the things that have caused him resentment and make amends to those he has injured, or at least have the intention of doing so. This means that he should endeavour to pay his debts, make amends as far as possible for any wrong he has done others, and so on. Then he should tell someone he can trust, usually a clergyman or psychiatrist, "the exact nature of his wrongs". After this he must make a daily inventory of his life, so that any resentments he may have will not become as a festering sore, driving him to waves of self-pity and bitterness, with their inevitable ending in a spree. Each morning he must invoke the aid of the Higher Power to help him during the day; each night he must thank Him for helping him to keep sober. Thus he is taught to live twenty-four hours at a time, forgetting the past, confident of the future. He is no longer anxious and apprehensive of the future; he feels himself in harmony with his fellow man; he no longer bears grudges and resentments; his whole personality has changed in that now, instead of being proud, arrogant, self-centred and emotionally childish, he has become mature, considerate of others, and an agreeable companion. In fact, unless he shows this personality change and "advances in objectivity and maturity", he will not remain sober. Then, to retain his humility and to avoid becoming self-centred again, he must constantly endeavour to help other inebriates. Once he loses interest in them the inevitable relapse is nigh.

Only about 10% of patients give up drinking at once. The majority of the others may remain sober for weeks or months and then relapse. It is an axiom of Alcoholics Anonymous in Sydney that the most dangerous periods for a relapse are after three days, when the urge for drink is still on the patient; after three weeks, when delayed acute symptoms are apt to appear, the so-called "dry horrors" in lay terminology; after three months, when all acute symptoms have disappeared and the patient feels so well that he thinks he is fully capable of controlling his drinking. It may take many relapses to convince the patient that he will never be able to drink normally. Many of the patients whom we gave up as hopeless in the early days have since returned and have become excellent members. Still others toy with the idea of Alcoholics Anonymous for months before they become convinced that they are true alcoholics and need treatment. And this is also true that, unless a patient is convinced that he needs treatment, it is waste of time for us to try to treat him.

However fantastic Alcoholics Anonymous may sound to you and however critical you may be of it, the fact remains that it works. Members meet weekly at branches and over the months one marvels at the transformation in their characters. From being men, down and out, profoundly unhappy and on the verge of despair, unable to meet their fellow man, they become happy, self-respecting men, who have once again become happy husbands and fathers, reunited to their families, always anxious to help others, and enjoying once again the confidence and good wishes of their employers. Two of the members have come here today to tell you their stories. By all the rules of psychiatry of three years ago their cases would have been regarded as hopeless. Today, by use of the methods of Alcoholics Anonymous, an excellent prognosis can be given in all similar cases.

Not all alcoholics are suitable for treatment by the methods of Alcoholics Anonymous. Many can be treated more effectively by other methods. This implies that psychiatrists must learn that alcoholism is very often a symptom of bodily and mental disorders, which must be treated rather than the alcoholism. This requires considerable finesse and experience in diagnosis. These things can be acquired only by the bitterness of experience and by a willingness to learn from mistakes, of which you will be reminded constantly by others.

The success of Alcoholics Anonymous in a field which has always been a heartbreak to psychiatrists should remind us that modern psychiatric methods appeal more to the intellect than to the emotions. As the methods of Alcoholics Anonymous can be successfully applied to the treatment of many patients with neuroses, we should learn the lesson that the emotions of many of our patients can be successfully directed to useful and profitable channels; this will enable them to lead happy, contented and useful lives, during which their neurotic symptoms will fall more and more into the background, until within a few months they will no longer worry the patients.

PSYCHOANALYSIS AND OTHER FORMS OF PSYCHOTHERAPY.[1]

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HAVING failed when preparing this paper to write an accurate summary of psychoanalysis, I subsequently read in the current number of the *International Journal of Psycho-Analysis*, just to hand, that this is a well-nigh impossible task.

In this final version, therefore, the aim has been to epitomize those aspects of psychoanalysis that have a bearing on the main themes of this paper. The first aim is to outline the scientific complexity of psychoanalysis. The secondary theme is this: since psychoanalysts are few and emotional illnesses many, other forms of psychotherapy possess palliative value, but only in proportion to the degree by which they do not worsen the unconscious emotional difficulties of the patient.

In abridging psychoanalysis I have endeavoured to avoid inaccuracies by inviting the criticisms of my colleagues; but I have departed from psychoanalytical usage by including both projection and introjection as varieties of identification, whereas projection is generally contrasted with identification. I have done so because I think it important to emphasize the point that projection and introjection are contrasting varieties of a similar mechanism. This opinion rests on published observations concerning the analysis of children, which assists understanding of psychotic and psychoneurotic illnesses.

Psychoanalysis is Ætiological Treatment.

"Psychoanalysis has bitten the dust" is a remark occasionally heard since the introduction of electroconvulsive therapy; on the other hand electroconvulsive therapy is considered by some to be shocking treatment!

Perhaps, however, the beneficial symptomatic results of convulsive and subconvulsive therapy will stimulate psychoanalysts to greater activity.

Psychoanalysis is a method of research as well as of treatment; and if the challenge leads to research concerning the psychological aspects of shock therapy, so much the better for both.

In any event there is promise that psychoanalysis may replace shock therapy in psychogenic psychotic disorders, though necessarily in the distant future, considering the disparity between the number of psychoanalysts and the vast army of sufferers from emotional illnesses. This opinion is based on reported amelioration by psychoanalysts of depressive and other prepsychotic states in children. It is claimed that these results came about through discovery of earlier causes than those previously observed. If this is so, increased psychoanalytical knowledge may lead to treatment of the psychotic adult on ætiological rather than palliative lines, which may bring about as profound changes in his personality as psychoanalysis has produced in neurotic character.

Psychoanalysis Means Freud.

Despite, however, the wealth of ætiological discoveries made through psychoanalysis, it is sometimes forgotten how many of the advances made in understanding and treating emotional illnesses are due to the original research of Sigmund Freud. This being so, it is advisable to recapitulate what Freud did.

In the first place, he invented a new technique. Freud adopted the procedure of free association, which simply means asking people to say what they are thinking and feeling. This does not seem to be a remarkable innovation; what seems surprising now is that no one before Freud thought of this objective way of studying the mind.

In the second place, he applied this new technique not to average people whose thinking departed little from so-called normal standards, but to sufferers from emotional illnesses, whose thoughts and feelings would be more striking. This may have been accidental and on a par with other accidents from which scientifically minded observers have repeatedly profited. Just as the functions of the thyreoid gland were not discovered by physiologists studying normal people, but by clinicians who noticed the departures from normal in patients whose glands were larger or smaller than average, so by asking neurotic patients of many and opposite types to say what they thought and felt Freud was enabled to observe facts which would have been less noticeable in comparatively normal people.

In the third place, he applied the new technique to himself and obtained evidence from his own free associations, which were stimulated by listening to his patients, that whatever he observed in pronounced degree in them also applied to himself. To anyone who has undergone psychoanalysis this constitutes Freud's most remarkable achievement, because such experience demonstrates how strong is the resistance to making such discoveries in oneself and how numerous the devices to prevent this.

One of the most important of these resistances is rationalization—that is, over-emphasizing certain facts in order to minimize other more important ones, an example being Adler's use of the term "inferiority complex" to over-emphasize what Freud called a feeling of inferiority. He did this as a defence against guilty feelings in himself of which he wished to remain unaware and which he apparently did not even observe in his patients. This being so, men more handicapped than Freud need to undergo a preparatory psychoanalysis before undertaking psychoanalysis of others. Because Jung also did not possess Freud's extremely rare quality of minimal resistance to recognition of his own unconscious motives, he too adopted defensive rationalizations. Incidentally, it is an interesting fact that, though Jung and Adler did not describe themselves as psychoanalysts, at any rate in later life, and were then at pains to label their systems "Analytical Psychology" and "Individual Psychology", respectively, they are often classed as psychoanalysts by uninformed people.

Freud's work is like Bright's on nephritis. Comparatively little that either wrote needed modification, and both welcomed revision as an application of scientific principles to their own fields. Freud also published explicitly speculative conceptions which have stimulated research.

It was once thought that a few months' personal experience of psychoanalysis would be sufficient preparation for any so-called normal person to practise psychoanalysis, but if Adler and Jung did even this it did not prevent their exploiting the process of rationalization.

Training for Psychoanalysis.

As the science and art of psychoanalysis developed it was found advisable not only to insist on full preparatory analysis for anyone who wished to practise as an analyst, but also to organize what is known as control analysis. This consists of the candidate analysing several types of neurotics and frequently discussing these subjects with an experienced analyst who is known as a training analyst. The candidate is also required to obtain at least six months' experience in a mental hospital and to attend courses of lectures. The four years' course is confined to medical graduates except in special circumstances. These are the rules of the British Psycho-Analytical Society, which is situated at the London Institute of Psycho-Analysis. It is now possible to obtain training in the Melbourne Institute for Psycho-Analysis at 111, Collins Street. Clara Lazar Geroe, member of the British Psycho-Analytical Society, is in charge of training (several Australian psychiatrists have been analysed) and Frank Graham is a director.

Nature of Psychoanalysis.

The most important factor in any analysis is the emotional relationship of the trainee or patient to the analyst. This mainly depends on the fact that the procedure of free association gradually reveals to the analyst

[1] Read at a meeting of the Australasian Association of Psychiatrists held on October 22 and 23, 1947, at Sydney.

and subsequently to the patient that the analyst is identified with other people to whom he is bound by ties of love and hate in all their varying shades and combinations, such as respect or intolerance, among the most important of these people being the patient's parents. The term "identification" is used to describe this confusion of the analyst with other persons and the word "transference" to the emotional attitudes that are expressed in consequence of identification. One of the mechanisms of identification is known as "projection"; this means diversion on to others of feelings about which we wish to remain unaware because realization of their existence would cause us to feel ashamed or guilty. An example of projection would be to over-emphasize our brother's envy of us as a means of avoiding recognition of the strength of our own envy of him. Projection, like every other unconscious mechanism, commenced in early childhood and cannot be undone unless realization of its existence in relation to the analyst is correlated with remembering how one felt and reacted when a child. A third necessity, if psychoanalysis is to be effective, is to draw the patient's attention to evidence of defence by projection occurring in his current life outside the analyst's consulting room. For instance, envy of the analyst is not only correlated with remembered envy of one's brother during childhood, but with envy of him during the analysis or with envy of someone whom the patient identifies with his brother. It is this mechanism of projection which underlies paranoid behaviour.

Another variety of identification is "introjection". This consists of turning feelings against oneself because one feels ashamed or guilty of feeling them towards others. An example of introjection would consist of identifying oneself with one's brother and then hating oneself as a defence against forbidden hate for him. This mechanism underlies psychotic depression. Incidentally, it is possible that manic-depressive insanity constitutes alternation between projectory and introjectory identification.

"Transference-resistance" is the name given to the intense effort put up by the patient to defend himself from realization of the mechanism of transference, which can only be proved to exist after laborious accumulation of evidence on the part of the analyst. The analyst then has to present the evidence in a convincing way, a process which is called interpretation. Incidentally, patients often realize that interpretations are correct after they have first denied them. "No", therefore, is often referred to by psychoanalysts as the unconscious affirmation.

Transference-interpretation goes on almost interminably. As soon as one transference situation is realized a new battle commences. Transference-interpretation, then, is not merely explanation. It is explanation of the emotional situations in analysis that are produced by and accompany transference.

The term "pre-conscious" is used to describe thoughts that are accessible to consciousness, but accessible with difficulty, an example being the thought "I envy my brother". It is a different thing to feel envious than to say it, however, and such feelings are usually, if not always, unconscious.

"Repression" is the name given to a type of exclusion of forbidden feelings from consciousness; and repression occurs without our being aware that they have been excluded. The term repression, however, is often loosely used by non-analysts instead of the word "suppression", which is conscious exclusion. This misconception leads some people to think that psychoanalysts advocate patients' engaging in activities—sexual ones, for instance—about which the patients consciously or unconsciously disapprove. However, as repression commenced during childhood, it cannot be undone without reliving in the transference situation the emotional disturbances responsible for its occurrence. In addition to projectory or introjectory identification and repression there are other unconscious ways of excluding unwanted feelings from consciousness, such as by denial of them, by reacting in the opposite direction, by displacement, by symbolic representation of them, or by converting them into physiological symptoms. The prevailing method or methods of exclusion probably determine the type of emotional illness from which any particular patient suffers, but what determines the choice of any variety of exclusion is even less certain. Observations made during analysis of young children, however, promise to throw more light on this question. Incidentally, if a certain type of psychotic illness depends on a particular way of excluding unwanted feelings from consciousness this would mean over-emphasis on one mechanism. For instance, melancholia could then be described as over-emphasis on introjection and mania as over-emphasis on projection, which, if correct, would link mania with paranoid behaviour. The comparative normality of the manic-depressive patient between attacks of mania and melancholia may be due to the temporary attainment of a balance, a conditioning comparable with the state of unstable equilibrium occurring in a tug-of-war. The average person in our civilization may have inadvertently struck a balance not only between projection and introjection, but also between all the other ways of excluding unconscious feelings. These ideas have been mentioned because of the opinion that speculation may be a forerunner of research.

The term "unconscious" is employed by analysts to include biological urges that were never conscious as well as those that have been excluded from consciousness. Because excluded feelings are more important from the practical point of view (in treatment) the word "unconscious" as used in this paper refers to these rather than to unconscious biological urges.

This being so, what has been written hitherto could be loosely stated thus: The unconscious mind exists because it has been divorced from consciousness, and free association allows the psychoanalyst to undo this dissociation. In short, psychoanalysts remarry the conscious and the unconscious.

Among the most important transference manifestations are those which recapitulate the sexual situations of childhood. Psychoanalysts, however, employ the word sexual in a wider sense than that generally used, and when referring to the more restricted meaning substitute the term "genital". Emotions connected with suckling and defæcation *et cetera* are called "pre-genital", because for the most part they precede the genital ones, and pre-genital and genital are together designated "sexual".

Psychoanalysts who treat children have observed even greater complications of the pre-genital emotions, and reactions from them, than those previously noticed by analysts who treat adults. These latter do not have the opportunity to make direct observations of children during analysis and have to rely on what adults remember of their childhood or express by acting out their revived childhood emotions.

If over-simplification is permissible as an aid to understanding, the general conception is something like this: because expression of pre-genital and genital emotions is forbidden to children, all manner of disguises are adopted, including their transformation into so-called naughtiness. This also is frowned upon, and so sexual emotions are further transformed into submissiveness as if the child were to say: "I mustn't be naughty, so I'll be too good". However, instead of expressing these distorted emotions in behaviour alone, children may develop aggressive or submissive phantasies which, because they are not put into practice, may be exaggerated to such a degree as to be horrifying or terrifying. Incidentally, it seems that many of these phantasies are never conscious. The greater the parents' tolerant affection, however, the less will be the child's unconscious exclusion of sexual emotions and of all their distortions, including the horrifying sadistic (sexual-aggressive) and terrifying masochistic (sexual-submissive) phantasies.

As to the Œdipus complex and its associated complexes, with all their wealth of unconscious sado-masochistic phantasies, these are experienced in the transference situation. In children five years old or less these sexual complexes are in the nascent state and, under the conditions of understanding acceptance by the analyst of all emotions as natural, are more and more openly expressed. The greater the degree with which adults remember the

sexual feelings of their childhood, the greater the scientific exactness of the analysis; but often the feelings are experienced in relation to the analyst only, these feelings being also correlated with childhood memories and with evidence of the analyst's identification with a parent. These situations are repeated again and again with increasing intensity and complexity, the analyst playing the part of one parent at one time and the other parent at another time, and even of both parents at the same time. What is called a deep analysis refers to one in which the pregenital impulses particularly are emotionally ventilated in great detail and over a very prolonged time.

Palliative Psychotherapies Derived from Psychoanalysis.

It is the wish to repudiate infantile sexuality which is responsible for the rationalizations of Jung, Adler and other psychotherapists, some of whom have also been called psychoanalysts. As, however, rationalization is overemphasis of actual facts, it must not be thought that their work is entirely valueless. For instance, Jung's conception of "archetypes" is of use as an elaboration of the fact that ontogeny epitomizes phylogeny psychologically as well as physiologically; and the terms "extravert" and "introvert" are useful for descriptive purposes in classifying types of personality. Also Adler's "organ inferiority" possesses validity as a factor in the genesis of neurosis even though it is intended to repudiate the importance of the castration complex. The point that is important, however, is that the schools of Jung, Adler and others have been comparatively sterile, whereas psychoanalysis is continually expanding in research, in treatment, and in application to new territory. In other words, these rationalization systems, though derived from psychoanalysis, are in the main palliative forms of psychotherapy which do little beyond relieving symptoms.

Other Palliative Psychotherapies Derived from Psychoanalysis.

Active.

As has been said, one of the procedures involved in psychoanalysis is interpretation. This is of chief value in linking the patient's childhood experiences as revealed by the transference emotions with his current history; but some psychotherapists make explanations derived from their psychoanalytical reading without knowledge of the indications. Even when they happen to be correct explanations, their untimely utterance may increase resistances rather than decrease them, and thus enable the patient to erect barriers of defence which he may continue to exploit should he subsequently seek treatment by a psychoanalyst. The best that can be said for premature interpretation is that, if the patient is of a certain type of personality, he might get relief of his symptoms and gain some intellectual insight which will be of comparatively little value, because it will not undo the divorce between the patient's conscious and unconscious minds, which is the main cause of his symptoms.

Some time ago a young married woman occupied the whole session telling me in great detail and in extremely technical psychoanalytical language the reasons why her problem mother had a problem daughter and a problem granddaughter. Modern youth would say she had been "psyched"! She postponed her next appointment indefinitely, thus debarring me from consulting her again. Hers was an extreme example of useless psychoanalytical knowledge, because on her own statement it had no appreciable effect on her behaviour, though she was a professional woman of above average intellect.

Another variety of psychoanalytical misconception is for the psychotherapist to encourage activities about which the patient feels unconsciously or consciously guilty. He may advise marriage, for instance, not being aware that this may be unconsciously forbidden to the patient, and that, until the unconscious causes of this personal taboo are ventilated in the transference, following the psychotherapist's advice is liable to bring about self-punishment of some sort, even by physical disease.

The psychoanalytical conception of a patient's taking advantage of his illness in some way, such as by using it as an excuse for avoiding responsibility, is technically labelled "epinosic gain". Psychoanalysts know that realization of wish for epinosic gain will tend to reach consciousness as the analysis progresses. Psychotherapists who have read about epinosic gain are apt to accuse their patients as soon as they observe evidence of its existence, and may produce a contrary result to that aimed at—increased rather than decreased exploitation of illness—as a defiant counter-action. In any case, psychoanalysts aim at allowing patients to discover as much as possible about themselves, and it requires time for this to occur.

Counter-transference is the psychoanalytical term for the analyst's emotional response to the patient, the degree of which is in inverse proportion to the emotional depth of the analyst's analysis. Unanalysed therapists are liable to become emotionally involved with their patients, either consciously or unconsciously, to an unsatisfactory degree, particularly if they essay psychoanalysis or interview their patients frequently.

Non-Active.

A part of psychoanalytical technique consists of the analyst's silently listening for long periods in order to collect an accumulation of evidence to use in interpretation. When eventually made, such interpretations are expressed in a tone of voice the calmness of which is in proportion to the degree of scientific detachment produced by the preparatory analysis. This personal experience of analysis also induces in the analyst realization of the inadvisability of expressing either approval or disapproval of the patient, whether explicit or implied.

Carl Rogers has written a book "Counseling and Psychotherapy", in which he describes a technique that he states is derived from psychoanalysis and in which he makes it clear that he does not regard himself as a psychoanalyst. His apparent aim was to evolve a method of psychotherapy of short duration in comparison with psychoanalysis, which would be of symptomatic benefit to mildly disturbed patients, such as those usually seen by counsellors. His technique consists of listening to what the patient has to say, without advising or making approving or disapproving comments, and without giving explanations derived from psychoanalytical reading. He makes remarks designed to draw attention to the emotional significance of what the patient is saying. He departs from psychoanalysis in that he suggests that the patient should solve the conscious problems that he talks about during the course of treatment, whereas psychoanalysts regard such solutions as a by-product of analysis resulting from ventilation in the transference situations of the emotional reasons which prevented action previously. Rogers also does more talking than a psychoanalyst, though to be sure a big proportion of his responses when his patients stop speaking consists of the non-committal expletive "Uh-m!". He has also collaborated with John Wallen in a smaller book "Counseling with Returned Servicemen".

A case report along similar lines to those adopted by Rogers, recorded in the book "Personality Factors and Counseling", of which Charles Curran is the author, concerns a youth who benefited from a short course of treatment. During these sessions he expressed hostility about his grandparents, who were mainly responsible for his upbringing, aggression which Curran gave him the opportunity to ventilate more and more openly by translating his earlier mild remarks into more direct statements, using such comments as "You mean that you think so and so". Following these expressions of impatience, the patient developed greater tolerance for his grandparents' intolerance.

Such a method bears a resemblance to that employed by psychoanalysts who listen without condemnation to aggressive remarks, whether directed against others or themselves, these all being potential material for future interpretation.

Curran's report also indicates that he encouraged his patient to enjoy simple activities such as dancing, of which his grandparents disapproved. Apart from self-punish-

ment, which would be negligible in this instance because of the comparative unimportance of the new pursuits, the patient probably would have made such decisions spontaneously, perhaps after ceasing to attend the clinic; this would result from absorbing Curran's less restrictive attitude by an unconscious process of identification with him. In addition, because behaviour consists of a compromise between conscious and unconscious wishes, psychoanalysts realize that, until patients become aware of the latter, they will tend to evade the advice of others; sometimes they evade advice by adopting a caricature of it, virtually saying by their actions: "This is what you advised. Now what do you think of your advice?"

In avoiding even expressions of approval, psychoanalysts take cognizance, among other considerations, of the fact that if certain things said by the patient are approved, silence on the part of the analyst when other things are said may be construed by the patient as disapproval. Patients often believe that the analyst disapproves when he is silent, and endeavour to extract condemnation by subtle remarks; but this attitude will abate in proportion to the degree to which the mechanism of projection thus expressed is ventilated by analysis. No psychoanalyst, however, whatever the depth of his analysis, is entirely free of unconscious disapproval of certain emotions, considering the fact that some unconscious taboos originate in babyhood; the most that can be said is that the deeper his analysis, the less the analyst will be influenced by unconscious aggression or by any other unconscious emotion.

This being so, members of the Rogers school of psychotherapists will find it more difficult to practise a state of scientific detachment than they probably realize; but, in comparison with active forms of analysis-like therapies, their methods hold promise of greater symptomatic benefit and certainly should do less harm. Perhaps this would hold even in patients who are more handicapped emotionally than those described in Rogers's book. In addition, considering the long duration of psychoanalysis and the small number of trained psychoanalysts, any form of therapy that relieves patients is of great practical value.

Hypnoanalysis.

The name hypnoanalysis implies it to be a form of psychotherapy departing little from psychoanalysis, but psychoanalysts do not use it.

After Freud discarded hypnosis he developed psychoanalysis, which allows the conscious and unconscious to meet, whereas hypnosis prevents them from meeting. In other words, hypnosis does not dissolve the divorce between conscious and unconscious, without which there could be no unconscious mind at all.

However, in a case report of a criminal psychopath entitled "Rebel without a Cause", the author, Lindner, claims pronounced relief of symptoms following a combination of psychoanalytical interpretation and hypnosis. The phonographically recorded associations and interpretations do not include any reference to the transference situation, and the symptomatic improvement is apparently due to increased intellectual insight, which ran parallel with expression of unconscious emotions while in a hypnotized state. Lindner suggested at the end of each hypnotic session that his patient should forget what transpired in the way of emotional abreaction. Though this would prevent the conscious and unconscious from being remarried, there might result a lessening of the degree of separation. Such a method might be expected, therefore, to produce greater symptomatic results than that accompanying intellectual insight alone, and on that account appears superior to the active forms of palliative psychotherapy mentioned.

L. Wolberg in his book "Hypnoanalysis" describes a patient suffering from schizophrenia who benefited from hypnosis; but his approach differs from psychoanalysis to a much greater degree than Lindner's, in that he used quite a lot of suggestion.

Narcoanalysis.

The method of narcoanalysis is to produce a state comparable with hypnosis, by means of drugs. Because of their narcotic effect the use of drugs would presumably increase the divorce between conscious and unconscious to an even greater extent than hypnosis. However, it would be likely that symptomatic improvement would be greater if it were employed in a similar way to that adopted by Lindner with hypnosis. It has a practical advantage over hypnosis that might offset its theoretical disadvantage, in that those who have not acquired the ability to hypnotize would be able to employ it. It is stated, however, that dosage is difficult, because the effect of drugs varies considerably in relation to the emotional state of each patient.

Suggestion and Psychoanalysis.

It has been asserted that psychoanalysis is nothing but suggestion. If a talkie-picture of a full psychoanalysis was screened for a non-analyst, he would be surprised at the difficulty and complexity of psychoanalysis. In addition, he would have the opportunity to observe how unremittingly a patient defends himself against realization of his unconscious motives; and how defence gradually gives place to attack as the analysis progresses. He would also hear the analyst admit mistakes and personal weaknesses with which the patient charges him. If he believed that suggestion rested on prestige, he would think psychoanalysis the direct opposite to suggestion.

The psychoanalyst's frankness actually benefits psychoanalysis, because it reduces the effect of the patient's unconscious phantasies concerning the omnipotence of the analyst. This leads to reduction of anxiety on the patient's part, which in turn encourages him to express his own previously unconscious phantasies of omnipotence. As a result he also airs accompanying guilty feelings of which he has been previously unaware; and their expression in words eventually delivers him from the dependent effects of hate, without which he could never become truly independent.

Though psychoanalysts try to avoid suggestion, it is impossible to do so entirely; but the more the patient works through his omnipotent phantasies, the less are the effects of suggestion. Suggestion, therefore, is present to greatest degree during the early period of analysis when it is linked up with positive transference. Positive transference and suggestion accompany any form of treatment, whether physiological or psychological, the sugestion "I hope to help you" being implicit in all. Psychoanalysts, however, are the only therapists who aim at abolishing the effects of suggestion with a view to removing the dependence of the patient that rests on both love and hate.

When a therapist aims at employing suggestion it would be well for him to remember that its effects are likely to be greater when it operates silently, a well-known example being injection of sterile water instead of morphine solution for psychogenic pain. Next in potency to silent suggestion is probably indirect suggestion. Before I resigned my appointment as honorary assistant physician at Sydney Hospital, to practise psychotherapy, I had a patient whose knees were anæsthetic and analgesic. I told the resident medical officer in her hearing that the area affected would diminish progressively each day, and she obligingly fulfilled my prophecy. This and similar experiences incline me to think that human beings have a desire to fulfil prophecy when it is in line with their own pre-conscious wishes. In this particular instance the patient had perhaps got over her wish to take advantage of her illness, having already received sufficient attention combined with rest from housework. I have realized since that I took a risk by making a statement that she could disprove, because patients react in the opposite direction when their transference is negative. I could have said: "If she wishes to get well, the area will probably diminish." In any event, the truth is always more potent than suggestion. Patients often express fear of suicide or insanity, which, however, in obsessional patients may be intended to alarm their friends and medical attendants. If one is convinced that the patient is not obsessional, it may be advisable to reduce anxiety even when the patient is being psychoanalysed. Psychoanalysis proceeds best

when the patient feels anxiety; but if it is too strong during the early phases this may interfere with the patient's obtaining a realistic attitude to his troubles, though as a matter of fact his capacity to tolerate anxiety increases during the course of analysis. There is another factor to consider also—the patient's unconscious wish to commit suicide or to become insane. The causes of this will be worked through as psychoanalysis progresses. Psychoanalysts have learnt that dread commonly expresses an unconscious wish combined with the conscious fear. This often applies to dread of suicide or insanity. As with other symptoms, silence concerning them on the therapist's part has the effect of indicating that the fear of suicide or insanity is not so important a symptom as the patient thinks. When in doubt, therefore, it is preferable to remain silent. If one speaks, however, it is as well to keep as close to the truth as possible, as by remarking: "No one goes insane while they fear insanity." Further aspects of suggestion and other forms of psychotherapy not derived from psychoanalysis will be omitted from this paper and left for discussion by others should they so wish.

Prophylactic Psychoanalysis.

The emotionally maladjusted grandmother, mother and daughter previously mentioned together emphasize the fact that emotional illness is familial. Psychoanalysts recognize the existence of heredity in the genesis of emotional illnesses; but, since at present the only feasible method of abolishing hereditary factors is for affected people to refrain from parenthood, it is wise to concentrate on the emotional causes.

As in the three generations of problem females, psychoanalysts find evidence in every patient of the harmful influence on him of his parents' maladjustments; and, when the patient happens to be a parent himself, of his harmful influence on his children. In addition, the more satisfactory the patient's analysis, the more beneficial his influence on his children and to a less extent on his parents.

The interaction between the three generations in the family of the professional woman cited produced an almost identical response in each, that of delinquent behaviour; but it is more usual for varying types of emotional illness to ensue, sometimes as reaction of a younger generation against an older.

As has been indicated, such familial vicious circles are likely to be more readily interrupted during childhood, when psychoanalysis is thought to prevent the onset of psychogenic psychosis, and presumably of other serious varieties of emotional illness, such as drug addiction, perversion, criminality, and psychosomatic disease.

Unanalysed parents, however, would have difficulty in putting up with the emotional crises of their children which occur from time to time during the course of every analysis. At present, therefore, analysis of young adults prior to parenthood would appear to be the most practical way to aim at breaking the vicious circle in the hope that such analysed parents would send their children for analysis should they need it.

Experience with Palliative Psychotherapy.

In my practice there have been patients with whom I considered it unwise to attempt full psychoanalysis for various reasons, such as the fact that they were elderly or border-line patients; though, incidentally, all definite psychotics have been referred to psychiatrists who do not specialize in psychotherapy.

The technique employed is, of course, much nearer to psychoanalysis than any of the derived psychotherapies mentioned, and is to a considerable extent adapted to each patient.

An example that comes to mind of a rather extreme departure from usual psychoanalytical method is the case of a middle-aged man who attended for about thirty sessions and spent almost the whole time in personal abuse. He drew attention in no measured terms to all the faults of the author on which previous patients had commented and to quite a number that they had unaccountably missed. One day he suddenly said: "This is my last visit; I'm going back to work next week."

A friend provided the information that the patient had recently experienced a severe disappointment concerning his employment, which he thought was responsible for the onset of the patient's inability to continue at work. He indicated that the conditions were such that he could not express his resentment without risking his job. These facts were never mentioned by the patient, and so I did not refer to them. Presumably, working off his resentment in the sessions enabled him to stop expressing it by absenting himself from his office.

What happened in this patient is somewhat similar to the experience of Rogers, whose implied acceptance of the naturalness of his patients' resentments was followed by symptomatic improvement, though apparently none of Rogers's patients abused him. Another difference is that Rogers adopts an attitude of warmth, whereas acceptance without appreciable warmth is the only way the author's behaviour in this case can be described! Rogers's suggestion to show affection is likely to produce subsequent resentment because patients' unconscious wishes can never be satisfied on account of the insatiable nature of instincts.

A second case in which the technique necessarily departed considerably from psychoanalytical procedure was that of a young woman of about thirty years who adopted an opposite attitude to the first patient as far as talking went. For months she uttered little more than a few sentences each session, a fact which debarred true psychoanalysis in itself, apart from the border-line nature of her illness. She made good symptomatic recovery, which was probably due to expressing her resentment by silence; refusal to speak had been a habit in her childhood and had been revived because of a recent emotional injury, as was mentioned in one of her expansive moods. Incidentally, this and the case of the male patient both demonstrated the fact that silent understanding is a therapeutic lever, as, of course, is the factor of time.

In describing these two cases I have not mentioned psychoanalytical explanations. In other words, I have under-emphasized the importance of my preparatory psychoanalysis in understanding and treating them. But, though they were seen before I read Rogers's book, the way they were handled could be described as a cross between non-active psychotherapy and psychoanalysis, with psychoanalysis predominating.

Apart from symptomatic improvement, the female patient provided some evidence concerning a variety of transference apparently unmentioned in psychoanalytical literature. The term "positive transference" is used in analysis to designate any degree of love, such as liking or respect, "negative transference" being any degree or variant of hate. Mild positive transference, accompanied by improvement in symptoms, usually occurs in the early stages of any form of psychotherapy; but there is a type of pseudo-positive transference when the patient makes extra rapid symptomatic improvement, or claims to have done so, as an excuse for stopping treatment prematurely.

The silent patient made slow improvement, some of which was due to a slight degree of positive transference, partly as a reaction from the negative transference expressed by her unconsciously aggressive silence. From the few things she said, however, there was evidence that some of her recovery was the result of occupying herself more than formerly, as by attending places of amusement and doing more housework, and that these changes constituted a postponed acceptance of advice tendered by another doctor prior to my treatment. There was evidence also that she wanted to deceive me into thinking my treatment entirely responsible for her improvement, and him into thinking that she was continuing to ignore his advice. Such a mechanism, which could be called double deception, is therefore a kind of pseudo-positive transference, seen in many other patients also, that suggests the possibility that symptomatic improvement may ensue after some at least of one's patients attend other practitioners. Recognition of its existence also encourages hope of palliation in non-analysable patients when one is consulted after they have failed to benefit from others' treatment.

The comparatively satisfactory results in these and other cases where I made little direct use of psychoanalytical

understanding suggests the probability that Rogers's non-active therapy is at least worth trial by those who are temperamentally disposed to standing by. As has been indicated, however, Rogers's technique needs modifying in the direction of even less activity, if non-analysts wish to avoid doing harm. On the other hand, those with sufficient curiosity might be impelled to learn how to be scientifically active. If so, they will seek to obtain the prolonged preparation for practising psychoanalysis prescribed by the training committees of the International Psycho-Analytical Association.

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Addendum.

As psychoneurosis is an unwieldy term, it would be advantageous to supplant it by a shorter word if this could be done without sacrificing its significant emphasis on both the mental and somatic nature of this emotional illness. Since, however, emotions themselves are expressed both psychologically and somatically (as, for instance, the emotion of fear, which comprises coincident conscious feeling and increased pulse rate *et cetera*), a term derived from the word emotion would appear to be suitable.

If, then, the basic syllable of the Latin word from which emotion is derived (*emovere*, to agitate), is combined with the usual suffix for illness (osis), the term "emosis" is formed. This retains the meaning of the longer word psychoneurosis and in itself draws attention by similarity to the importance of emotion in its ætiology, facts which should outweigh possible objections by etymological purists who obsessionally oppose the introduction of compound words derived from different languages even when they possess other advantages, such as clarity. By its dissimilarity from the word psychosis, emosis emphasizes the differences between these two emotional disabilities, differences which appear to include a qualitative factor, though whether this is greater than the quantitative factor is for future research to determine. Adoption of the word emosis instead of psychoneurosis might at least have the practical advantage of reducing the habit of calling psychoneurosis "nerves" because of the widespread dread of insanity. Alternatively, the word emosis could be used instead of the phrase "emotional illness" to include all varieties of this condition whether psychotic, psychoneurotic, addictive, criminal, or psychosomatic. Incidentally, emotic would be a less clumsy word than psychosomatic.

INDIVIDUAL OR INDIVIDUUM: A SURVEY OF TOTALITARIAN AND TERMITE COMMUNITIES.[1]

By JOHN BOSTOCK,
Brisbane.

Man as Individuum.

IT is customary to talk of individual psychology as a study of the behaviour of an individual without considering that the individual may be in fact an individuum consisting of many sectionalized psychologies. An individuum is defined as an indivisible entity.

In primitive organisms constructed of identical cells, as in volvox, it is simple to regard a volvox psychology as the sum of that of its members. We might concede that each has a separate quota of mind. In higher animals and in man mind is regarded as the functional expression of a specialized brain sector and it is customary to regard the mind as a unique quality of the whole organism.

This outlook blinds us to other considerations. Our anthropomorphic consciousness conceives all consciousness of the same category, whereas there are endless variations. Groups of cells, as in the basal nuclei, the cervical plexus or the anterior horn of the spinal cord, may have an awareness of their special function concerning which the main consciousness is quite unaware.

The human body has a complex series of organs, a veritable chemical laboratory producing chemicals as diverse as sugar to adrenaline, thyroxine to an antibody. If there is an infection, millions of fighting cells are rushed to the focal point, the arsenals work overtime and the cell barracks multiplies its inhabitants. The heart power station accelerates, the heat-regulating mechanism raises the temperature of the body. There is a tendency to regard such occurrences as automatic physical processes, but this evades the issue. Certain phenomena, such as the psychogenic causes of physical diseases and of cancer, suggest that the relationship is not so simple. Organs sometimes have a degree of autonomy, which accounts for many of the vagaries in our patients. In the main the limbs and organs of the body, the leucocytes and lymphocytes have the minds of slaves intent on one function. They work, they die, unknown, unsung, unheard; they are content to serve the master mind which resides in the cortex and basal nuclei.

As I deliever this address I am a totalitarian organism. My controlling presiding body, house of representatives, præsidium, dictator, mind—call it what you will—has the joys of creation and can control offence and defence. I exist by the grace of my slave members, limbs and organs, whose one-track mind keeps them with remarkable precision to a single viewpoint, their specialized job.

Before I sing in terms of excessive joy at my personal totalitarian empire, it is well to remember that my controlling genius may plunge it into destruction through an ill-planned life. Wine, food, women, war or overwork may lead to destruction. Also I am at the mercy of my slaves, who may tire of their menial tasks and commence an orgy of uncontrolled reproduction. The spectre of cancer is always round the corner.

I have sketched, albeit inadequately, a conception of a totalitarian organism in which its parts are cogs in a wheel of life of which they have no control. Life, death and destiny are in the hands of a master dictator. There is no separate existence. They are chained to an automatic obedience. When the master dies, they too die.

Such is the pattern of every organism. Commencing as a single unit, it fuses, divides and grows on the totalitarian plan. For the advantages of size, complexity and travel, the majority of its members must be content to be the humble hewers of wood, drawers of water. Only a few will serve the hierarchy of the soul. They have bartered immortality of the single cell for the mortality of man. It would seem that in the case of man Nature had no alternative. Totalitarianism was essential.

Is the Community an Individuum?

Let us now ask ourselves whether our conception of the individual has not been too circumscribed. It is conventional to speak of man and wife and even family as a unit. By a simple extension there is village, town, city, each presenting an integrated pattern. If a man could take a helicopter and hover over our city streets and then study a termite colony he would see a strange resemblance. He would regard this city of Sydney, with its pathways, tunnels, factories, farms and corporate life, as an organic whole quite comparable with a termite colony. Could he take his helicopter over the whole of Australia, he would be convinced that he could speak of the whole human life on this continent as a whole life unit. If he looked closely and long enough, he might say that there was an increasing resemblance to a totalitarian social unit, an individuum, as seen in a termite colony. He would find that the soul, or the directing body, appeared to be drifting into one administrative head, at a distance from the rest of the members, who seemed divorced from the ruling centre. As he saw their daily toil he might infer that with the termite they had bartered freedom for efficiency.

[1] From a paper entitled "Why Australia Needs the Psychiatrist", read at a meeting of the Australasian Association of Psychiatrists held on October 22 and 23, 1947, at Sydney.

A Termite Colony is an Individuum.

In a termite colony there are soldiers and workers. Artificial gardens are tended; the colony is artificially warmed. The queen is chief executive. When she dies, the colony dies; it is the price for ultra-specialism and an efficient life of routine. Each worker has its job, each has its share of food, each has a prescribed task. The activities are completely stereotyped; there is no deviation from plan. It is a bureaucrat's paradise.

There is an uncanny resemblance between the totalitarianism of the termite and the human body—soldiers and phagocytes, queen bee and brain, fungus gardens and organs of digestion, workers and blood corpuscles. This comparison has been well described by Eugene N. Marais (in "The Soul of the White Ant"), to whom I am indebted for much of my knowledge of termite psychology. The termite colony must be regarded as a single individual in the same sense as man is an individual.

It would seem that every organism at the onset of evolutionary change is faced with an awesome possibility. It must decide on the alternatives of freedom with its attendant risks and stereotypy eliminating many risks. The termite chose the latter.

Its efficiency is extraordinary; it has eliminated most dangers at the total expense of individual freedom. Each member is bound to a limited territory and by a remarkable telepathic influence is for ever under the influence of the queen dictator. A scientist must pay homage to the genius of the termite, but the lover of freedom is horrified at its soulless exploitation of the individual.

Australia—An Individuum.

If it is conceded that a human Australia can be conceived as an individuum, in the termite sense, it is germane to ask questions as to its psychology. There is no reason to suppose that an entirely new Australian psychology will be necessary. The fundamentals of individual psychology still apply. The personality pattern of our Great Australia Individuum will depend upon that of its eight million members and their ruling soul.

As a normal psychology has its morbid phases needing a psychiatrist, it is equally certain that the Great Australia Individuum will not live without turmoil and tribulation. It will need psychiatrists—many of them if it is to gain a measure of happiness. Already much of the necessary knowledge is at the hands of our Psychiatric Association. Group psychology is a well-known entity. There is evidence that the Australia individuum is greatly in need of a psychiatrist.

Totalitarianism, Socialism and the Termite.

Totalitarianism and the termite spirit are not new. They commenced with the first family and the first slave. The story of totalitarianism is the story of history. At the urge of the aggressive and acquisitive instincts—the ego's curse—men took hold of cities and countries, churches and customs. They created totalitarian entities based on the fabric of their own desires. The spirit of freedom flourished in Greece and it sickened in Rome, almost died in the dark ages and was reborn in the Renaissance. Freedom was persecuted with relentless sincerity; it survived only through our vast earth and poor communication system, which permitted men to flee from persecution and find repose in some haven of liberty.

Let it not be forgotten that if the mediæval world had possessed finger prints, wireless, telephones and modern transport, the torch of freedom would have been completely extinguished. Frontiers would have been closed to the dissatisfied.

Totalitarianism is the story both of socialism and of big business. It is a misconception to consider that certain brands are inherently harmful, that a pink is delightful and a red is anathema. The only difference is time. Totalitarianism is a dynamic process which proceeds inexorably to its logical end, controlling power at the top and stereotyped automatism below.

The term "socialism" is often wrongly used to include the extreme of complete collectivism and mild social cooperation. Advocates of the latter have followed the principles of decentralization and adopted the rule that, whilst a degree of regimentation is necessary, this should be minimum and consistent with adequate results and not a maximum as a matter of policy in search of power.

Influences to Totalitarianism.

It is regrettable that modern science has given to humanity influences which may quite easily result in the reinstitution of a serfdom from which there may be no escape.

If we analyse group or mass behaviour there are certain tendencies which tip the scales towards a totalitarian *régime*, whether applied through force of arms, as in contemporary times in certain countries, through force of doctrine, as in eras of religious fanaticism, through urge for efficiency, as in America, through pursuit of humanitarian principles, as by the Fabians and other left-winged intellectuals, or through force of alleged expediency under today's Australian conditions.

Totalitarianism is possible owing to certain fundamental psychological qualities. Each individual: (*a*) is highly suggestible; (*b*) is highly persuadable; (*c*) has the instinct of flight which impels him to security from danger; (*d*) tends to be submissive rather than aggressive; (*e*) wants bread and pleasure, so "falls" for those who promise the better life; (*f*) is inherently lazy and prefers the ease of stereotyped thought to the difficulty of self-thinking; (*g*) lives by habit, and this is easily acquired; (*h*) is subject to the sex urge; marriage and children, closing the door to adventure, impel him to seek security.

It is unfortunate that the above "soft" tendencies make the mass very susceptible to minorities who by urge to power plan to influence the majority to a certain line of action. As in war, the initiative carries a major advantage. Needless to say, the eternal see-saw between the aggressors and the complacent has been altered by modern means for suggestion and persuasion. A man at a microphone or at the wheel of a syndicated Press can move millions. At long last the great ones of the earth have discovered the great secret of the termite queen. They can influence directly over distance.

Professor Eric Ashby has illustrated the manner in which stereotyped thought can be produced on a totalitarian basis. The English reader in Russia gives to the new generation the last and authentic word pattern of western civilization. It excludes all "rosy" texts and gives passages on "the slums of Chicago (Upton Sinclair), the East End of London (Jack London), a general strike in Britain (Galsworthy), the story of a Negro being burned to death in Arkansas (Haywood), and an extract about Mr. Squeers (Dickens). The detailed syllabus for Shakespeare includes a study of the development of capitalism. 'Hamlet' is used in this to illustrate the exposure of court aristocracy."

The efficiency of this type of propaganda was well shown in both world wars and it has not died with the atomic bomb. One might recall the millions of Germans, Italians and Japanese who sincerely believed in their role as supermen.

As already stated, the soft are the prey of the strong. The psychologist realizes that the interplay of psychological forces does not end here. The basic differences in the sexes has important repercussions. Soft men create a masculine protest in women. As the power flows femininewards in woman's traditional quest for security, the way is left clearer for the aggressives and the doctrinaire. Whenever a country's alleged strong men are too soft to enter the arena of politics on account of its alleged nastiness, the writing is on the wall. The termite road to serfdom is open wide.

Australia's Progress to Totalitarianism.

It is pertinent to ask how far Australia has forsaken individualism in search of totalitarianism. Let us rummage the memories of one lifetime and walk our city streets today.

Instead of men being activated by the spirit of progress to the stars, Australians ask how much the Government will allow. Instead of men glorying in their strength and hating charity, they are taught to turn to seek the safety

of a Government dole. Instead of fair return in work for money, they say "anything will do". The forthright and sturdy "you-be-damned" attitude of personal liberty is being replaced by one of "what does it matter? something will turn up", and there is always the old-age pension. Law is being widely flouted, and many regulations are so outmoded that evasion of the law becomes normal community behaviour. They are taught not that man only gets what he works for, but that everything should be free, as if Australia were to be a millennial state for schizophrenics and hysterics.

Lest an occasional citizen be exploited, the whole country has to be criss-crossed, intertwined and smothered with red tape, but with a curious inconsistency, a touch of schizophrenic genius, the bookmaker and State lottery seller are left untouched.

If men work hard to create independence in old age, they are taxed to the limits of capacity and finally discover that the wasteful and thriftless receive a life pension from which the thrifty are debarred. They learn that this is a loafer's paradise in which industry is penalized and sloth rewarded.

Lest workers be exploited there has arisen an ultra-specialism of trades, and each is rigidly confined in its occupational field. This is sometimes pushed to such extreme limits that loss of efficiency and needless increase of overall costs are produced. The guiding principle is not "let us work for the whole job", but "I am only concerned with my own part of my job".

Although the number of Commonwealth, State and civic servants is daily increasing to an unprecedented degree, and examples of their inefficiency are obvious to all, the protests of the taxpayers are as feeble as the blows of a neurasthenic.

Whereas our fathers took a burning interest in politics, believing that freedom was a reality worth a struggle for its possession, the elections of today are as tame as a hypochondriacs' picnic. The highlight is an occasional moan without enthusiasm or action.

It is intriguing to know that this stereotyped spirit of the psychoneurotic is reflected in architecture. Scott-Moncrieff, speaking of modern architecture, says:

> Although we may be impressed by photographs of concrete sanatoria and the like, particularly when these are taken in glorious sunlight and before the concrete has had time to crack and discolour, I think most of us experience a certain dissatisfaction in them. It is not merely that we feel that some grace has gone out of life; we also feel that some disgrace has crept in. We see expressed in those depersonalized lines, that card-index facade, something of the ruthless mechanical mentality that, in another manifestation, has given us totalitarian government. There is nothing surprising in this. Cultural phases are expressed in their architecture. Are these buildings slick and efficient?—so, within limitations, is totalitarian government! The age that produces the one might be expected to produce the other, but that does not mean that either is desirable or a part of the main and more creditable course of human achievement.

Totalitarianism Abroad.

America.

At the risk of my confusing you, let us take our helicopter over America. We shall find evidences of a totalitarian whole, not brought about by a ruling centre as in Russia, but by a national urge to efficiency. The drive is so prodigious that its industrial output staggers the imagination. The produce of factory and farm is magnificent in quality and of such abundance that America is regarded as the rock which will save the world from starvation. The secret weapon behind this magnificence is stereotypy. By ultra-specialism the worker and the executive become extremely skilled at their job. The work is enormously facilitated and output soars. The country becomes enormously and even fantastically rich.

It is a biological fact that in the evolutionary ascent over-specialization leads to stultification. The opportunities of adaptation are lessened and the species becomes entirely dependent upon a limited environment. You will recall the fate of the dinosaur and recollect the predicament of our Australian native bear, which can thrive only on a few species of Eucalypt. Specialization is always dangerous to the individual; mass specialism may be a tragedy.

Each individual is so dependent upon the other that stoppage in a small industry can upset the livelihood of thousands and the efficiency of the whole. Our observer in the itinerant helicopter would have noted this in Australia as it hovered over foundries and wharves. In America the results would have been even more visible.

It is an axiom that nothing can be purchased except at a price. We must decide whether the advantages of stereotypy, with its staggering gains, offset its collosal disadvantages. Does its efficiency compensate for its dangers inherent on over-centralization, whereby one flaw in one cog can upset the whole complex organism and dangerously gigantic power flows into the hands of a few men?

Let us ask if stereotypy is helpful to the individual.

In a recent issue of *The Rotarian*, Austin C. Lescarboura, of New York, writes of his fellow countrymen:

> Look at the common man. He has become an automaton. Where his father used to gather the family for a lusty sing around the old upright piano, he sits down, pushes a button, and leans back to take on his nightly ration of radio music. Great music no doubt, the kind his forebears could only dream of, but the ease with which he obtains it has cost him his own individual expression.
>
> Or again in sports. The common man pays millions of dollars to watch professional athletes exercise their muscles and eyes while he grows paunchy and dull. Week after week he sits in the movies, lapping up the intellectual pap they serve him and wondering why he doesn't get ahead. And every day he devours the comics while a world of wisdom gathers dust at the neighbourhood library.
>
> Even his work has become humdrum. He pilots an elevator up and down, or turns down Nut 92, or files papers from A through K. Much of his work could be done by automatic machinery, and it will be when management is ready to lay out for it.
>
> We in the United States have become a race of specialists. We know our own jobs and we know them well. The fact that we are better mechanics, better accountants and better farmers has, it is true, made us a powerful nation. Yet we make poor use of the leisure our system yields us and stumble rather than plan our way through the increasingly dense woods of human relations. Out of this grow many of our current social problems—the discontent of the labouring millions, the restlessness of our rich families, the political messes which we must bear, the frightening international situation.

Lescarboura writes a plea for the antithesis of stereotypy: "The era of the common man! What we need is an era of the uncommon man!"

Russia.

It would be inconsistent to quote America without reference to totalitarian Russia.

Our helicopter observer would be impressed with the termite resemblances in its vast military machine, its enormous factories, its large communal farms, the seeming adoration of the masses for the leader and the extraordinary control of the many by a centralized minority. As he tripped about the countryside his vision would be obscured by the totalitarian blanket of secrecy, the closed frontiers, the firm hand of the secret police, the weight of bureaucratic control and the glamour of a superb propaganda organization.

Aldous Huxley, discussing Russia, points out that Russian totalitarianism is based on force and that means do not justify ends, means produce their own ends.

> Ruthlessness begets resentment; resentment must be kept down by force. As usual the chief result of violence is the necessity to use more violence. Such then is Soviet planning—well-intentioned, but making use of evil means that are producing results utterly unlike those which the original makers of the revolution intended to produce.

Psychologists are well aware of the results of conflict and repression. There is much evidence that the Russian

individuum is not proceeding entirely to plan and there are certainly no psychological reasons to warrant our imitation of Russian totalitarianism and stereotypy.

The Costs of Stereotypy.

If he had fitted a supersonic rocket and flitted between the countries of the world from Russia through Europe to Chicago, Montevideo and every other haunt of man, our observer would have noted that wherever man creates large-scale enterprise, whether in public works, civil services, military service, free enterprise, factories or organizations, he invariably introduces two unbidden influences. The first is bureaucracy with its initiative-destroying and soul-deadening entanglement of red tape. The second is the more elusive but very tangible quality of emotional blunting. In small enterprise there is the warm patriarchal feeling of the home, but as it increases in size, the worker loses the warmth of personal contact with a now impersonal boss and approaches the cold card index life of the totalitarian. All too frequently there is a third, in gratification of lust for power and its unlovely sequelæ.

Civilization has the unhappy knack of posing the wrong question. Its theorists, its pink academicians and left wing evangels argue that, because the millennium exists in their own phantasy thought and can be written on paper, it will work in large-scale enterprise. According to their view national totalitarian enterprise is as lovely as a lover's dream and as efficient as a turbo-generator in glorious mountain scenery.

If they could lose their myopic enthusiasm and face facts they would pose the question thus: "In view of the psychological difficulties in interpersonal relationships, what is the maximum size organization for complete living?" They would find that the critical point for maximum emotional efficiency would be very low. The harmonious integration of twenty personalities is an immense task and with each addition it becomes more difficult. On a peace-time basis the possibilities of a successful national set-up for complete living is of the nature of a celluloid doll surviving the heat of an atomic furnace. The sad story of large-scale enterprise does not end here. The theorist imagines that it proceeds efficiently on its own momentum. Unfortunately interpersonal relationships are in ceaseless flux. A trifling incident such as a pay cheque in the wrong envelope or a word misunderstood can wreck an organization overnight. In this connexion it is unfortunate that the efficiency and harmony of the whole unit depend on the guiding executive. He needs a high-grade intelligence quotient and a superpersonality. As such men are rare and the majority of men are mediocre, the scales are balanced against successful large-scale enterprise.

The sands of public and private enterprise are strewn thick with the debris of failures. Initial success leads to growth which through the quality of size carries the beginnings of decay. The intellectually honest, successful man will almost invariably regret that the growth of his affairs has led to inefficiency, but, like the man on the tiger's back, he cannot unsaddle. This applies also to public undertakings. It is high time our leaders faced these problems and worked out a scale of values. Thus no hospital should have more than 400 beds, no medical organization employ more than 20 doctors, no clerical business employ more than 100 employees, no manufacturing unit have more than 50 men under one departmental manager. In the realm of public affairs no city council should cater for a population of more than 50,000, State government should be in the hands of almost completely autonomous councils controlling little State areas with a limited population of not more than 100,000 people. My figures are merely suggestive and almost certainly too high.

Aldous Huxley in "Ends and Means" asks: "When does a group become a crowd?" He considers that "it is significant that Jesus had only twelve apostles; that the Benedictines were divided into groups of ten under a dean (Latin *decanus*, from Greek δέκα, ten); that ten is the number of individuals constituting a Communist cell. Committees of more than a dozen members are found to be unmanageably large. Eight is the perfect number for a dinner party. The most successful Quaker meetings are generally meetings at which few people are present. Educationists agree that the most satisfactory size for a class is between eight and fifteen. In armies the smallest unit is about ten. The witches' 'coven' was a group of thirteen. And so on. All evidence points clearly to the fact that there is an optimum size for groups and that this optimum is round about ten for groups meeting for social, religious or intellectual purposes, and from ten to thirty for groups engaged in manual work. This being so, it is clear that the units of self-government should be groups of the optimum size. If they are smaller than the optimum, they will fail to develop that emotional field which gives to group activity its characteristic quality, while the available quantity of pooled information and experience will be inadequate. If they are larger than the optimum, they will tend to split into subgroups of the optimum size or, if the constituent individuals remain together in a crowd, there will be a danger of their relapsing into the crowd's sub-human stupidity and emotionality."

I am reminded that possibly the most efficient large-scale organization in Queensland, if not in Australia, is the Queensland Ambulance Transport Brigade, which provides ambulances for sick persons. The reason lies in its acceptance of the principle of decentralization. Every centre has a major degree of local autonomy; every centre competes with the others in a race for efficiency.

The great problem before humanity is not how it can centralize to efficiency, but how can it decentralize to happiness. As Huxley remarks: "the political road to a better society is, I repeat, the road of decentralization and responsible self-government".

Bound up with this problem is the goal of the ideal man. Throughout the centuries this has been the charitable, non-attached and kindly man. The ideal is entirely inconsistent with the product of totalitarian upbringing. This product is chained with unbreakable fetters to the oars in a totalitarian ship, totalitarianism having become his religion.

Responsibility of the Psychiatrist.

As an association we are a non-political organization. Psychiatry cannot exclude politics from its agenda. "Politics" is merely an executive-cognative-conative section of mass psychology. Party politics is largely a political sentiment. I believe that those of us who, like myself, have leftish tendencies should review the position and ask ourselves whether we have not strayed too far from the middle way of safety.

The members of our Psychiatric Association understand "mass psychology" and can see in clear perspective the appalling dangers of mass regimentation. They visualize the inherent imperfections of the human mind, which lays open a myriad ways to aggressive action by others; they are not hoodwinked by political platitudes, as to free this or that by all, but realize that the only psychological way to psychological integration is by the habit of hard work to correct standards for adequate rewards with community ideals.

As such it is our duty to inform the public that:

1. Individual happiness requires the maximum of individual liberty with the minimum of community restraint.
2. Sacrifice of liberty ends in totalitarianism, aggressions, repressions, extinction of adequate liberty, and the creation of a privileged bureaucratic class.
3. There is urgent need for an Australian bill of individual rights, so that each individual may know the inalienable extent of his liberty.
4. Although science has made some enormous and material strides, there is great scope for improvement in the national executive department of mass psychology (politics). Over-centralization is producing individual apathy and hopelessness. A means must be adopted by reform of the franchise so that advantages of interest and intimacy through decentralization may be achieved.
5. Education must be planned to create a more realistic approach to community and individual living. This entails education both for youth and adults.

By a coincidence this paper is produced at a time when public interest is aroused by a plan for nationalization of banks. Tomorrow it will be insurance, medicine or the steel industry.

Members of our learned association are not experts on the ramification of commerce, but we are at liberty to ask this very pertinent question: Are the advantages of nationalization sufficient to offset the extremely grave psychological dangers which follow in the wake of nationalization and centralization?

Faced with the experience of our own Government departments, the example of the totalitarian States of Hitler, Mussolini and Stalin, and not least the termite colony, I question whether a single psychiatrist of repute would be prepared to answer in the affirmative. The majority will give an emphatic "No".

Perhaps in ten thousand years of further evolution the dross in the human psyche may have been eradicated to a point where totalitarianism is safe, but when this occurs it will be unnecessary, since every man will of his own initiative feel rightly, think rightly and act rightly.

Meanwhile we must admit our imperfections, but not seek to eradicate them by experimental psychological measures which might imperil our precious treasure of personal liberty.

Reviews.

SYMPTOMS AND SIGNS IN DIAGNOSIS.

"SYMPTOMS AND SIGNS IN CLINICAL MEDICINE: AN INTRODUCTION TO MEDICAL DIAGNOSIS", by E. Noble Chamberlain, is now in its fourth edition since 1936.[1] There is a tremendous amount of information clearly expounded in its 442 pages and the 346 illustrations make understanding rapid and complete and must assist those with a visual memory. The material is set out in a systematic fashion, interrogation and examination of the patient are dealt with first and then comes a section on external characteristics of disease, followed by others on the various systems of the body, fever, medical operation and instrumental investigation, clinical pathology and biochemistry. The chapters on examination of sick children and radiology are contributed by two colleagues from Liverpool. The table of contents and index facilitate reference to any subject.

The book is written to assist the student when he first enters the hospital after studying the purer sciences of anatomy and physiology and also to refresh the memory of those already practising clinical medicine. These aims have been successfully accomplished. There are very few medical practitioners whose technique of physical examination would not be improved after the reading of this book.

HEADACHE.

A SMALL BOOK entitled "Headache" will fill many with the desire of possession.[2] Headache is much commoner than the common cold, and most sufferers will assert that, apart from the relief produced by analgesics, it is equally resistant to treatment. The reader will expect of such a book an exposition of the present state of knowledge, a reasonable anatomical and physiological approach, information which will improve his diagnostic capacity, and finally an evaluation of the many treatments which have been advocated.

The initial chapter deals with observations of Wolff and his associates upon physical stimulation of structures within the head. Wolff's summary is quoted: "The principal mechanisms concerned in headache are 'inflammation, traction, displacement and distension of the pain-sensitive structures. As a source of pain the cranial vascular structures far outweigh in number and distribution all others'." Ray and Wolff's diagrams provide excellent illustration for this section. The physiological summary reveals the regrettable paucity of knowledge of this common symptom.

The initial chapter sets the pattern for the book. It is a review, but not a critical review, of the literature. Herein lies its value and its weakness. It is written without the exercise of much critical faculty and needs to be read critically. The literature and the laboratory tend to take precedence over the clinician.

Thus, important clinical manifestations are unrecorded. Amongst these may be mentioned the poor response of psychogenic headache to analgesics and the reference of headache following lumbar puncture to the back of the neck and sometimes to the shoulders. The associated cervical rigidity sometimes leads to the belief that meningitis has supervened—hence the importance of recognition of this point. Again, the highly characteristic march of dysæsthesiæ over one side of the body in migraine is not mentioned. Yet this symptom is of endless fascination to the clinician, and patients are frequently referred to the consultant because it raises the suspicion of Jacksonian epilepsy.

Apart from the schematic tables the text is readable. An occasional telling phrase enlivens the narrative. "The tidal wave of vitamin therapy has not spared migraine." "What American cannot recall the picture of the happy, healthy, cheerful, successful, robust, vivacious person who has 'joined the regulars', contrasted with the pale, tired, dull, discouraged, headachy person who failed to get 'The Job', 'The Sale', 'The Girl' because he didn't use a certain brand of intestinal trauma." Conservative rhinologists will agree that "The anatomical obviousness of the nose, together with its accessibility and the relative ease with which it lends itself to operative interference, has led to an exaggerated conception of the incidence of nasal headache. Headache of true nasal origin comprises only a small percentage of all headaches. Contrary to popular opinion, sinusitis is not a common cause of headache, and the false diagnosis of sinusitis because of headache often leads to much unnecessary and often meddlesome treatment". On the other hand it hardly seems necessary to evoke phylogenetic reasons to explain tenseness of the posterior cervical musculature in emotional disturbances. "The residual tenseness in the neck muscles is a vestige of the head-up alertness of quadrupeds in times of stress." And again: "Higher animals and primitive man were constantly beset by physical dangers, by larger and more ferocious animals, storms, hunger and the importunate urgings of the testicles. The senses of smell, hearing and sight were the principal defence mechanisms on guard at all times and doubly alert in times of threat. Raising the nose, eyes and ears as high as possible by lifting the face was accompanied by the contraction of the posterior nuchal muscles. In modern society the physical dangers have been replaced by stock market bears, the thunder storms by the evangelist, the tribal chieftain by the policeman and tax collector. Despite the intellectualization of our stresses, many people react in the primitive pattern and face them with head-up alertness, suffering a residual tension in the neck muscles." The memory of mankind is long! The occasional injection of an unexplained sentence is due to the method of construction of the text from the literature and does not contribute to the ease of reading. For example, apparently in dealing with orthostatic headache, one reads that: "Disturbances in 17-ketosteroid excretion cycles may be important." Some of the case histories are unnecessary. Those dealing with meningitis, for example, teach nothing of the type of headache, nor of meningitis—nothing more than that headache is a prominent symptom of meningitis.

The author deals with treatment rationally, some methods evoking, to use his own words, "guarded enthusiasm". But in many types of headache the impression remains that many patients suffer least if not subjected to some of the modern refinements of treatment. However, acceptance of such a state of affairs would stultify advancement, and fail to satisfy the craving of human nature for treatment. Indeed, yielding to this is probably as frequently the cause of relief as the actual mode of treatment used. As with Ménière's syndrome, a rational evaluation of methods of treatment is very desirable, and equally difficult to provide. The psychological equipment of the proponents of various methods is concerned as much as that of the patient. The latter cannot be altered, the former is the cause of much that is unscientific in medical literature. However, such a book as this will better the lot of the patient by aiding accuracy of diagnosis. If diagnosis is accurate, the fewer

[1] "Symptoms and Signs in Clinical Medicine: An Introduction to Medical Diagnosis", by E. Noble Chamberlain, M.D., M.Sc., F.R.C.P.; Fourth Edition; 1947. Bristol: John Wright and Sons, Limited. London: Simpkin Marshall (1941), Limited. 8¾" × 5½", pp. 472, with many illustrations, some of them coloured. Price: 30s.

[2] "Headache", by Louis G. Moench, M.D.; 1947. Chicago: The Year Book Publishers, Incorporated. 8" × 5¼", pp. 208, with many illustrations. Price: $3.50.

will be the means of treatment applied by even the most hopeful physician.

The production of the book is good. The arrangement of the subject matter is logical, although "Migraine Headache of Emotional Origin" is separated from the chapter devoted to migraine and occupies an equal space with that devoted to psychogenic headache. More space might well be devoted to this most common type of headache. Those diagrams culled from various authors have been well chosen. Some figures seem unnecessary, for example, the radiograph showing maxillary sinusitis. The line diagrams of herniation of a pulp nucleus and of fracture of the odontoid process are more appropriate to the student's blackboard. Figure 47 is an example of a common failure—the reproduction of a radiograph which fails to demonstrate clearly the desired point.

In summary, it may be said that few will fail to benefit from reading the book. It is to be hoped that the author will continue to prepare future editions, rewriting and improving upon the present presentation. The book will then have a definite place in medical literature.

EAR, NOSE AND THROAT DISEASES.

THE important place filled by I. Simson Hall's compact text "Diseases of the Nose, Throat and Ear" is evident in the fact that a fourth edition has now appeared.[1] The text and general format remain much the same as in the previous edition. Experience in the use of penicillin has caused some modification of the outlook in ear, nose and throat infections, and this has now been taken into account in the text.

Recent advances in the problem of deafness are referred to and an outline of the fenestration operation for otosclerosis is included. The treatment of Ménière's disease is up to date and describes the use of histamine and of nicotinic acid, salt restriction *et cetera*. It is regretted that the section on deaf mutism fails to include maternal rubella as a frequent cause.

The author is to be congratulated on his efforts, for this is a most useful book and contains all that the student or busy general practitioner is likely to require in preparation for examination, or for speedy reference.

DIAGNOSIS.

"METHODS OF DIAGNOSIS", by Clendening and Hashinger,[2] is a book of 868 pages, of which 27 are taken up by the index. In its form it is a combination of two books—clinical methods and differential diagnosis.

The following quotation is taken from the preface: "The average text-book in medicine takes up the description of diseases under their proper names, and is not therefore of help to the physician at the bedside of his patient until after he has determined what disease is present. This work therefore discusses the diagnostic possibilities of a given case, starting from the symptoms or from the signs, or from the laboratory data or X-ray picture, or the electrocardiographic record which the patient presents." It is quite obvious that the authors have kept this ambition constantly in mind and not deviated from it. The prospective purchaser must therefore ask himself: "Do I want a book of differential diagnosis of symptoms and signs, or do I prefer a book with its information set out under disease headings?"

We find this book wanting as a textbook on methods of diagnosis from the approach of the diagnostic possibilities of a given case. It may be that other textbooks of differential diagnosis are more complete; or that we are irritated by the constant repetition that is inevitable in a book of this nature; or that, in an attempt at completion, short incomplete sketches are cheek by jowl with a hundred-page article on one subject; or that statistics appear too frequently and without sufficient significance. All these pertain, and we think that for these reasons the book cannot be commended to either student or practitioner.

Those who do purchase the book, however, will much enjoy Part I, which occupies pages 1 to 77. It is headed "Principia Diagnostica", with chapter headings (*a*) "Logic and Diagnosis" and (*b*) "The Organon of Diagnosis". These chapters briefly describe the principles of logic which apply in reaching a diagnosis. They are well written and succinct, with carefully chosen quotations and examples, and will much delight those of us who graduate from schools in which logic is not part of the premedical curriculum.

Few further comments are necessary. The paper is excellent and the type is good. Photographic illustrations are adequate, but the drawn pictures are not of a high standard.

SICKNESS WITHOUT SORROW.

BY sending a copy of "Sickness Without Sorrow" to a friend you will contribute to the Food for Britain Fund, to which all royalties are being devoted by the apparently long-suffering author and the illustrator.[1] The pictures will make the recipient smile—so, too, should the letterpress, especially if he is not a doctor. A study of the glossary should be useful to patients, and possibly make them more intelligible to doctors; perhaps the incorporation of some exposition of patients' ideas about pathology in future editions might be instructive to the medical profession. In a good cause we may well increase the circulation of stories old and new.

RETROPUBIC URINARY SURGERY.

THE publication late in 1945 by Terence Millin, of London, of a hitherto unexploited method of surgical attack on the obstructing prostate excited widespread interest and comment. Not entirely satisfied with any of the conventional routes, Millin had approached the prostate from above the pubes, but without opening the bladder, carrying out what was in effect a perineal prostatectomy done from the anterior aspect, and reported a series of twenty-eight cases. He has now published a short monograph, "Retropubic Urinary Surgery", in which the essential chapters are those based on his experience of over two hundred retropubic prostatectomies.[2] It is a welcome and a well-timed publication.

We candidly feel that the book could have been made shorter without loss of its value. Some of the early chapters have rather a broad application to prostatic surgery generally than a specific one to retropubic surgery, and here and there are frank, if minor, irrelevancies. However, there is plenty of "meat" in it, and the chapters on surgical anatomy, surgical technique and case management generally are good. The illustrations are excellent, particularly those relative to surgical technique. Some of the others, and the text also in parts, might by unkind people be not unreasonably regarded as padding. However, Millin is Irish, so perhaps this explains it. But there really are too many temperature charts, and the editing is not good. Not every case report is granted a principal verb, and here and there we are given such pieces of information as "F normal /1; S excellent", "S = good. F = D/N = normal /1", "prostatectomy advised lest recurrence of post-operative urinary retention", and so on. To "anticepticise" an operation field seems an unfortunate method of preparing it. Capital letters are used with abandon, and it seems a little unjust that they should be granted to the house surgeon, but not to Millin's assistant.

Still, there appears to be no question that Millin has evolved and put into practical application a new and sound method of prostatectomy, and his book describes most adequately how it is done. The chapters, too, on the subjects of prostatic and bladder carcinoma, the calculous prostate and traumatic rupture of the prostatic urethra are good and provide much food for thought. This book should be read by every urologist. It will not be found difficult nor will it take long. We look forward to the publication in a few years' time of a second edition, embodying Millin's even riper experience, and in a form which will be more in keeping than is this initial publication with the importance of the subject matter.

[1] "Diseases of the Nose, Throat and Ear: A Handbook for Students and Practitioners", by I. Simson Hall, M.B., Ch.B., F.R.C.P.E., F.R.C.S.E.; Fourth Edition; 1948. Edinburgh: E. and S. Livingstone, Limited. 7¼" × 4¾", pp. 476, with many illustrations, some of them coloured. Price: 15s.

[2] "Methods of Diagnosis", by Logan Clendening, M.D., F.A.C.P., and Edward H. Hashinger, M.D., F.A.C.P.; 1947. St. Louis: The C. V. Mosby Company. Melbourne: W. Ramsay (Surgical) Proprietary, Limited. 9½" × 6½", pp. 884, with many illustrations. Price: 94s.

[1] "Sickness Without Sorrow", by "G.P.", with illustrations by Alec Gurney; 1947. Melbourne: Robertson and Mullens, Limited. 8¾" × 5¾", pp. 88, with many illustrations. Price: 6s.

[2] "Retropubic Urinary Surgery", by Terence Millin, M.A., M.Ch. (Dublin), F.R.C.S., F.R.C.S.I.; 1947. Edinburgh: E. and S. Livingstone, Limited. 9¾" × 7", pp. 216, with many illustrations, some of them coloured. Price: 25s.

The Medical Journal of Australia

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All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

References to articles and books should be carefully checked. In a reference the following information should be given without abbreviation: initials of author, surname of author, full title of article, name of journal, volume, full date (month, day and year), number of the first page of the article. If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

Authors who are not accustomed to preparing drawings or photographic prints for reproduction are invited to seek the advice of the Editor.

THE NEGLECTED STUDY OF COMPARATIVE PHYSIOLOGY.

THE study of the comparative physiology of animals presents an almost unexplored field for research. Of course, considerable attention has been directed towards the physiology of the domestic animals, and this subject is naturally an integral part of the curriculum in veterinary teaching, but outside this narrow domain and the few observations made on experimental laboratory rats, guinea-pigs and the like there is unfortunately not only ignorance but indifference. The comparative anatomy of Australian fauna, though possessing a literature of its own, still has room for extension and some amendment, but over the functional needs there broods a curious silence. Why should the engaging koala show such extraordinary limitation in its choice of food; what is there in the leaves of some six species of eucalyptus which is missing from the leaves of the remaining three hundred species? Why has the captive platypus to be given earthworms in numbers which the animal could never encounter in its natural habitat? Does the milk of marsupials resemble that of the higher mammals or does it conform more to the nourishment obtained by the fœtuses of the true mammals *in utero*? For example, does such marsupial milk show a freedom from lactose which in the higher mammal is required for movement of the young when born; does it contain liberal amounts of iron which ordinary milk does not? What is the condition of the circulation in the immature marsupial when expelled from the uterus? Has anyone taken an electrocardiogram of the platypus with its muscular right atrio-ventricular valve or of the dugong which has the two heart ventricles largely separated from each other? One could go on asking such questions for an extended and wearisome period. No doubt the apparent remoteness of such problems from matters affecting human welfare has in part led to this neglect of what should be a fascinating field of inquiry, but no one dare prophesy that such a study might not throw light on the functioning of the higher mammals, for example, on the endocrinology of the reproductive system, as was hinted at by the late Sir Colin MacKenzie.

There is another region of animal knowledge which has not been properly explored by men of science, but remains in the possession of animal breeders and trainers. A mass of lore has gathered around the stable and the farm to which the attention of biologists might well be directed. No doubt a considerable fraction is hearsay, such as telegony, that is, the influence of the first sire on subsequent progeny, an opinion held tenaciously by breeders, but totally opposed to biological principles and experiments. On the other hand there is a residue well worthy of study in their untutored beliefs. Thus it has been known for many years that linseed oil administered orally improves the coat of horses; indeed a dramatic change is often effected, and yet it is only quite recently that linoleic and linolenic acids, derived from linseed oil, have been dignified with the suggested appellation of vitamin *F* and the favouring action of these unsaturated fatty acids on human skin been described. It is a matter of some little surprise that each member of the profession has not already received from a manufacturing firm an ampoule containing one millilitre of linseed oil with glowing testimonials as to its value in pathological skin conditions! Certain fodder stuffs like bran are supposed to increase the fat enveloping the heart and so impede its action, leading to a falling off in staying power during a race. One must ask, by the way, whether any textbook of physiology mentions just what purpose is served by the rich investment of fat which the adult heart usually displays; and those physiological specialists who work out the physics and thermodynamics of the heart muscle, whilst telling us all about adenosin and creatin phosphate and the complicated oxidation of glucose, never stoop to inform us why the myocardium is so rich in sterols. There are medical men who assert with emphasis that strenuous exercises in boyhood do no harm, but let them announce the same doctrine to a horse trainer and see what reception they will get!

Breeders of cats have known for many decades that without liver in their diet these animals, or at least certain breeds of them, are likely to develop anæmia. Parrots and cockatoos have been cured of coprophagy possibly for centuries by giving them capsicum and other vegetable substances which modern methods have shown to be rich in vitamin *C*. Every dealer in pigs can recognize the different texture of subcutaneous fat in animals which have had soft food and those which have had a topping off in hard food. Those farmers who breed for bacon and those managers of factories in which bacon is cured know well how great this difference can be. Texture, melting point and taste are profoundly affected by the animal's diet before it is killed, and when a glut of fruit is used as hog food the result is a falling off in the quality of the bacon. Has this dependence of the character of body fat upon diet been given any attention in human physiology or pathology?

The pastoralist and the grazier are rapidly becoming aware of the importance of trace elements in the feeding of flocks and herds. Actually the essential role of these cryptotrophic factors should have been recognized many years ago when it was discovered that no marine fish could live in artificially prepared sea water no matter what care was taken to have all the known constituents correctly assembled. We may surmise that as sea water was the primordial environment of life and the basis of body fluid,

each and every substance present may be indispensable. Traces of gold—and according to certain business prospectuses gold is present in sea water—may one day be included in the category of metallic substances necessary for animal life. Poultry experts inform us that chickens cannot be reared on a timber floor; apparently something they get from mother earth is necessary for growth.

But when all is said in favour of the practical application of the lore of farm and shearing shed as well as the scientific study of domestic animals to human welfare, there remains a great realm of research which should appeal by its purely scientific, and, one might almost add, romantic interest. Australia has a wonderful vertebrate fauna, but in how many universities are these fascinating creatures studied? Too often the biologist centres his attention on lowly worms, molluscs and crustaceans, not that the study of these is without its value, and yet all the time there are anatomical details in marsupials and monotremes awaiting elucidation. When we come to the comparative physiology of these creatures we find nothing but blank pages. A golden opportunity for brilliant research is offered to our young biologists. Why do they not seize it? In this particular respect we cannot blame Australians for not following the lead of other lands, for in no country is comparative physiology pursued with any zest. The naturalist has found that the spider can secrete a sticky web for capture of insects and a smooth, non-adhesive web for its own transport. Are there two types of web secreted by different glands? Is the secretion of each under voluntary control? Are different spinnerets employed? What biochemical divergences give the respective qualities? Even in the case of bees, which may be described as domestic animals, the strange biochemistry of the formation of wax has so far not invited research. Bees apparently can determine at will whether an immature female is to become a sterile worker or a complete female "queen". Is this a question of vitamin *E* or are there deeper mysteries involved? The business man who finds that his hitherto reliable typist-secretary has suddenly become incompetent or that his telephone girl starts giving sequent wrong numbers and then discovers that each has begun to wear an engagement ring may be inclined to think that there is something after all in the bees' device. Apathy elsewhere should not be taken as an excuse for any Australian failure to study the functioning of those beautiful creatures which only his own country can display. The call for research is clamant. The pioneer spirit can and should show its presence by the early embarking on this noble voyage of discovery.

Current Comment.

DEATH AFTER MAJOR SURGERY.

DEATH is a fairly rare complication of major surgical procedures these days, but there appears to be little available analysis of those deaths that do occur, a regrettable omission if the death rate is to be further reduced. One such analysis has been made by Frank H. Tanner and George Cullen, of Lincoln, Nebraska.[1] In two general hospitals during the years 1943, 1944 and 1945 a total of 5699 major surgical procedures were recorded; 138 of the subjects died (a total death rate of 2·4%), and in 64 cases autopsy was performed; the paper deals with 57 of the autopsy reports. Tanner and Cullen found difficulty in obtaining suitable corresponding data for comparison purposes, and statistical grouping and analysis of their findings are not very satisfactory; there are, however, certain points of interest. A relatively large number of the deaths followed so-called emergency procedures and a relatively large number of patients had been subjected to more than one operative procedure during the period in hospital immediately preceding death. Tanner and Cullen feel that in some cases a longer delay, sufficient to allow a more accurate diagnosis and more supportive therapy, might have been justified and perhaps some repeated operations might have been avoided. As they point out:

> The pathologist rarely does an autopsy on a patient who dies because an operation was too long delayed (i.e. few hours to few days), but he frequently sees the poor results from operations attempted before adequate diagnostic methods, conservative and supportive therapeutic measures have been carried out.

Circumstances vary, of course, but the thought is worth pondering.

In the series there were relatively few deaths due to purely operative or technical factors and none primarily due to anæsthesia. This is a good record, especially when it is appreciated that in some cases in which an operative factor was the significant one, non-operative factors were also present. Non-operative factors were responsible for most of the deaths, heart disease, pulmonary embolus and "unsuccessful removal of pathological processes by surgical methods" accounting for the majority of this group. In some cases, however, a condition was found that had not been diagnosed clinically or that presented diagnostic difficulties, and the wise, though apparently obvious, remark is made that, if a patient is not doing well after operation, it is well to bear in mind the possible presence of a disease process wholly unrelated to the primary surgical condition.

A comment is made on the fact that most of the clinical records were complete except that they lacked a written note regarding the clinical opinion as to cause of death. As is pointed out, this deprives the clinician of an opportunity to test his clinical acumen and suggests a lack of interest in the case with an unsuccessful result. As well the pathologist receives no indication of specific problems causing the clinician concern and the post-mortem examination may be so much the less revealing. The surgeon who has the courage to invite the pathologist to test both his surgical skill and his clinical judgement stands to gain in the end.

[1] *Surgery, Gynecology and Obstetrics*, October, 1947.

GYNÆCOLOGICAL BLEEDING.

A COMPREHENSIVE discussion on "gynecologic bleeding" was held by members of the Section on Obstetrics and Gynecology at the Ninety-Sixth Annual Session of the American Medical Association in June, 1947. The subject was covered systematically in a series of authoritative papers followed by a question and answer discussion. All of this material has been published[1] and those interested would be well repaid by a first-hand study of the wealth of information presented. It is possible here to refer to only a few of the main considerations.

S. R. M. Reynolds, who presented a summary of current concepts of the physiological basis of menstruation, compares the vascular pattern in the uterus with the components of the peripheral vascular tree in other parts of the body and states that the principal differences lie in the presence in the uterus of many supposed arteriovenous anastomoses, numerous endometrial coiled arterioles and extensive subepithelial venous and capillary lakes. Of equal importance, though usually less emphasized, is the fact that the tissue in which these vascular

[1] *The Journal of the American Medical Association*, November 1, 1947.

structures lie is loose and spongy, and the vascular elements are developed out of all proportion to the immediate metabolic requirements of the tissue. Apparently this vascular arrangement is adapted to supply rapidly the placental villi of an invading trophoblast when an ovum begins to become implanted. The sequence of events is the same in anovulatory cycles, but the degree of vascular development is much less. In either event, the demands of cyclic endocrine activity impose the necessity of tearing down the vascular bed in the spongy tissue if implantation does not take place. Reynolds has summarized and set out in diagrams the changes in vascular pattern in the various stages of the menstrual cycle. He goes on to discuss an hypothesis on which the menstrual mechanism may be based, possibly bound up with the lymphatic drainage of the endometrium and the removal of transuded plasma protein. Reference is also made to a "menstrual toxin", the presence of which is generally admitted, but it is not clear whether this toxin is a cause of the onset of menstruation or an effect following vasoconstriction and degeneration of proteins.

The subject of menometrorrhagia during adolescence was considered by C. F. Fluhmann, who deprecated the use of such terms as "puberty bleeding", "adolescent bleeding" and "menopausal bleeding". According to him there are no such entities, since there is no single specific factor concerned; any of the various causes which lead to abnormal uterine hæmorrhage may be effective at any time from the menarche to the menopause. Instances have been reported of bleeding during adolescence from fibromyomata, inflammatory lesions of the pelvic organs, incomplete abortions, systemic diseases, endocrine disorders and cancer of the *cervix uteri*. Usually, however, menorrhagia or metrorrhagia during adolescence is due to the nature of the early menstrual cycles, which are prone to be irregular, and to the existence of an endocrine disorder which results in endometrial hyperplasia. Pain is not a feature of the latter condition and clinical examination does not as a rule reveal any significant abnormality. The ovaries are sometimes enlarged, and the presence of cystic degeneration of the ovaries and the absence of *corpora lutea* are characteristic. In instances of long standing there is no evidence of ovulation. The final diagnosis is usually made on histological examination of the endometrium, which is thick and œdematous with a dense cellular stroma and glands showing all degrees of proliferation. It is essentially a self-limited disease, and ovulation with the restoration of normal menses is to be anticipated, though it may be quite long delayed. Treatment aims at combating the blood loss by iron medication and the cause is attacked by the administration of endocrine products. Curettage may occasionally be indicated, but Fluhmann is opposed to irradiation because of possible damage to the ovaries. Thyreoid extract is the most valuable form of treatment for patients with low basal metabolic rates. The available anterior pituitary lobe preparations are of no value. Large doses of either œstrogen or progesterone are extremely effective in the control of bleeding. Pregneninolone is of value, but the use of androgens is contraindicated for patients of this age group.

A. H. Curtis, in a paper on functional bleeding, defines it as loss of blood from the uterus without demonstrable pathological cause. The term includes all cases of excessive uterine bleeding ascribable to endocrine disturbances except those in which there are tumours of the endocrine glands, but not those due to high blood pressure, blood dyscrasias and other systemic affections. The accepted opinion is that pituitary or hypothalamic dysfunction causes bleeding through excessive stimulation or inadequate control of ovarian activity, particularly in the elaboration of œstrogen. For the adolescent, functional bleeding may be dangerously excessive, but near the menopause it is rarely so. In considering diagnosis Curtis points out that the diagnosis of menopausal bleeding has been made difficult by œstrogen therapy, which should be discontinued three weeks before a diagnostic curettage. Intractable menopausal bleeding is rarely purely functional and requires careful investigation. The treatment of functional bleeding is largely symptomatic and empirical, but a good deal can often be done. Therapeutic curettage is seldom required. Ergot preparations are of limited value; the use of vitamins *B*, *C* and *K* is still in the experimental stage. Curtis considers that irradiation merits a permanent place in the treatment of menopausal bleeding. The value of thyreoid medication in selected cases is widely accepted. Otherwise hormone therapy is in a confused state, but Curtis prefers androgens to œstrogens, holding that the hazard of masculization from androgen therapy has been overstressed. He gives three tablets (each of ten grammes) of methyl-testosterone per day for free bleeding, and two tablets daily for moderate bleeding. In the few cases in which this fails to control bleeding, additional intramuscular injections of 25 milligrammes of testosterone are given on alternate days. Androgen therapy is not a specific cure, but provides effective symptomatic control if repeated each month.

The final aspect of the subject, menopausal bleeding, was discussed by J. P. Pratt, who stressed the importance of determining the cause and of making a general survey of the patient, not neglecting the patient's outlook, especially anxiety about cancer. Hyperplasia of the endometrium due to an abnormally persistent or relatively excessive œstrogenic influence is a common cause of menopausal bleeding and is diagnosed by the history and the histological appearance of the endometrium obtained by curettage; hormone therapy, curettage, irradiation and even hysterectomy are to be considered in treatment. Other causes of menopausal bleeding are cancer (the most important cause at this stage), cervical and endometrial polypi, adenomyosis and fibromyomata of the uterus, functioning tumours of the ovary, occasionally the rupture of a sclerotic uterine blood vessel without other abnormality, and inflammatory conditions of the uterus and adnexa. Mild bleeding may be associated with senile vaginitis, eversion of the urethral mucosa, abrasion or ulceration of a prolapsed cervix and pyometra. Other miscellaneous causes are systemic disease, endocrine disorders, nutritional disorders and vitamin deficiencies. At all times, however, as Pratt makes clear, cancer must be borne in mind—"a murderous disease with an insidious onset" in which hope of cure rests on early diagnosis. "Correct interpretation of every instance of menopausal bleeding would expose the brutal invader." Cancer of the cervix is particularly treacherous, as bleeding may be relatively late in onset and trivial in amount, but generally speaking menopausal bleeding due to cancer provides the outstanding object lesson in the importance of establishing an exact cause for the bleeding if possible, and this extends to bleeding at all ages. As Pratt puts it very simply: "Women should be encouraged to seek an explanation of every bleeding, no matter how trivial. This field offers the physician a great opportunity for giving comfort and saving life."

DR. REGINALD WEBSTER AND RESEARCH AT THE CHILDREN'S HOSPITAL, MELBOURNE.

In another place in this issue will be found an announcement of the appointment of Dr. Reginald Webster to the Mary and Evelyn Burton Research Fellowship and to the curatorship of a pathological museum which will be named after him. This appointment will cause a great deal of satisfaction to those who know and value Dr. Webster's work. His service to the Children's Hospital, Melbourne, has been long and faithful. Many of his observations have been published in this journal, and those who followed their sequence will recall the vivid style and clarity with which he described his specimens. Two special volumes of his studies have been reprinted. The appointment is particularly fortunate in that it makes possible a continuance of the pathological work and research at the Children's Hospital to which Dr. Webster has devoted so many years of his professional life. Dr. Webster's influence has extended far beyond the walls of the one institution, and it would be no exaggeration to say that his work has provided a large part of the foundation on which Australian pædiatrics has been built.

Abstracts from Medical Literature.

RADIOLOGY.

Soft Tissue Changes in Early Acute Osteomyelitis.

George J. Baylin and John C. Glenn (*American Journal of Roentgenology*, August, 1947) state that in each case of suspected osteomyelitis X-ray studies of bone and soft tissue are desirable. Significant changes are manifest in the soft parts surrounding the involved bones and are at times present within a matter of hours after the onset of bone infection. The most consistent change in early active osteomyelitis is a roughening of the normally sharp line of demarcation between the subcutaneous shadow and the muscle bundles. Concomitant with this is the tendency to obliteration of the intermuscular cleavage planes. The usual normal subject has a very clear-cut demarcation at the muscle subcutaneous tissue line, but in acute osteomyelitis there is regularly present within twenty-four hours considerable distortion at this line, characterized chiefly by transverse irregular lines of increased density extending from the muscle borders into the subcutaneous shadows. These lines are not particularly straight or regular in length or width, but seem to produce a criss-cross pattern that suggests they may be vascular and lymphatic channels that have become patent or dilated. Apparently a similar change occurs in the usually clear-cut intermuscular planes that normally stand out as lines of decreased density, for in most cases of early acute osteomyelitis it is very difficult to separate the muscle compartments. The changes described are obviously not of the same degree in every case and may actually vary both with the severity and the duration of the disease. They may be evident in the X-ray film even in the absence of clinical evidence of tissue swelling, although after the first forty-eight hours there is usually both clinical and X-ray evidence of enlargement of the soft parts. Perhaps the first radiological changes are an expression of tissue œdema that is subclinical. The most important fact concerning the changes under discussion is their distribution in the tissues. In all cases in which these early soft part abnormalities were seen, they extended throughout the tissues along the length of the bone involved. In other words, when the upper end or any part of the femur was the seat of infection the soft parts along the entire length of the bone on the lateral, medial, anterior and posterior aspects reflected the changes. The abnormality does not tend to pass beyond the joints unless the joints themselves are likewise involved.

Epipericardial Fat Shadows.

John F. Holt (*Radiology*, May, 1947) states that radiologically visible accumulations of epipericardial fat have been classically associated with the left side of the heart. Less well recognized but even more bothersome is the occasional occurrence of similar fat pads along the right lateral margin of the cardiac shadow. In this position the fat deposits, which are located between the pericardium and the pericardial pleura, may assume large proportions and simulate significant intrathoracic lesions. The shape of a right-sided fat pad is neither consistent nor entirely characteristic. In frontal projection it most frequently assumes a triangular configuration, the outer margin of which is somewhat convex. In lateral view, the fat pad invariably is located at the anterior costo-phrenic sulcus and the extremities of its smoothly marginated bow-shaped posterior border appear to fuse gently with the anterior chest wall. Significant intrathoracic lesions in the lower portions of the lungs seldom have this appearance and are more apt to be posterior in position.

Pulmonary Hæmosiderosis.

L. D. W. Scott (*British Journal of Radiology*, March, 1947) states that hæmosiderin may be deposited in the lungs in any disorder causing pulmonary hæmorrhage, but, so far as is known, in only two diseases can the deposits be shown radiologically. Pulmonary hæmosiderosis in children seems to be a rare disease characterized by anæmia and occasional hæmoptysis. The X-ray picture is one of miliary shadows in the lungs which can be shown at post-mortem examination to be due to focal accumulations of iron pigment. Hæmosiderosis of the lungs, sufficiently dense to affect the X-ray picture, has also been recognized as occurring very infrequently in cases of mitral stenosis. X-ray examination of the chest shows miliary opacities in both lungs—an appearance which suggests miliary congestion. These opacities do not alter in appearance over long periods of time in contrast with the changes produced by pulmonary œdema. Pathological examination shows that the opacities are due to focal deposits of hæmosiderin. More commonly, but by no means in every case of mitral stenosis, a careful search may show what appears to be a minor degree of focal hæmosiderosis. In this type of case the radiological signs could easily be overlooked. The more obvious examples of the condition occurred in patients who had had frequent hæmoptysis, but this association was not observed in every case.

Gout.

Edward F. Rosenberg and Robert A. Arens (*Radiology*, August, 1947) state that the radiographic changes which are encountered in patients with gout may be expected to reflect the progressive clinical and pathological features of this disease. The earliest X-ray evidence of changes resulting from gout is not to be expected until fairly late and should be looked for in the bunion joint. The first notable change is the appearance of a zone of osteoporosis in the medial aspect of the head of the first metatarsal bone and base of the first phalanx. As the gouty process becomes more extensive, this zone of osteoporosis becomes frankly cystic. At the sites of such lesions the bony structure is completely obliterated and X-ray pictures consequently show a "punched-out" appearance. The next stage of gouty destruction results in narrowing of the joint spaces as a result of erosion and obliteration of cartilages by the gouty pannus. Because this process is uneven, surfaces of joints sometimes become very irregular. Continued use of such joints produces traumatic effects, as a result of which marginal hypertrophic changes appear. An even more destructive effect may be seen where tophaceous deposits in the ends of bones expand greatly. These lesions may cause widespread obliteration of the epiphyses and joints. Entire joints may disappear at such sites, leaving bony stumps projecting into a formless tophaceous mass. In some advanced instances, one sees the results of combined processes, including erosions, marginal proliferations and fractures of remaining shreds of bone structure. An occasional result of large uratic deposits in epiphyseal regions is expansion of the cortex of bones. This may produce an appearance in the X-ray films resembling somewhat the picture seen when certain tumours of bone produce expansile effects, for example, giant-cell tumours or osteogenic sarcomata. Normal X-ray appearances of joints do not necessarily exclude the presence of gouty lesions. If pannus formation predominates and if this process is not accompanied by invasion of the epiphyseal bone by gouty lesions, fairly extensive pathological lesions may be present in joints which cast no abnormal shadows.

The Association of Achalasia of the Cardia with Œsophageal Carcinoma.

P. Baer and K. Sicher (*British Journal of Radiology*, December, 1947) state that achalasia produces conditions favourable for the subsequent development of a carcinoma of the œsophagus. This carcinoma, though usually extensive, may be difficult to demonstrate owing to the great elongation or tortuosity of the œsophagus in these cases. In addition there will be a considerable residue in the œsophagus, which makes a satisfactory examination difficult and can give misleading appearances. Furthermore, the neoplasm is usually situated in the mid-thoracic part of the œsophagus, separated from the cardia by a dilated but otherwise—as far as X-ray findings go—normal segment of œsophagus. Reliable X-ray findings can, therefore, be obtained only if the examination is carried out after the œsophagus has been emptied of food residues and if the whole length of the œsophagus is properly visualized. The association of carcinoma and achalasia can be suspected if, in a patient with proved achalasia, after a symptom-free interval, a recurrence of dysphagia with disproportionate loss of weight, blood-stained vomitus and retrosternal pain occurs. The ætiology of an œsophageal carcinoma developing secondarily to achalasia may be explained by the fact that stasis of food sets up a chronic œsophagitis with ulceration of the mucous membrane. It appears that, in an attempt at repair, there is mucosal proliferation and formation of papillomata which may undergo a malignant change.

Fibrous Dysplasia of Bone.

Franklin B. Bogart and Allison E. Imler (*American Journal of Roentgenology*, October, 1947) state that fibrous dysplasia is the term at present applied to a group of conditions which in the past have been designated by a variety of names. The bone lesions are characterized by one or more of the following features: broadening or expansion of the cortex; thinning of the cortex by encroachment from the

medullary side; trabeculation which suggests cystic change, when as a matter of fact true cystic changes seldom exist; a fine ground glass appearance in the medullary portion of the shaft of affected long bones. The lesions begin to develop during childhood or adolescence, but may not be discovered until adult life. The condition is thought by most authorities to represent a skeletal developmental anomaly. It is thought that many radiologists and other medical men do not appreciate the fact that comparatively mild cases of this disorder are encountered fairly frequently. While several bones are usually involved, cases may occur in which only one bone shows changes. Single lesions are frequently mistaken for some other pathological condition, most frequently fibrocystic disease. While small cartilaginous islands are occasionally seen in fibrous dysplasia, the basic microscopical picture is one of fibrous tissue replacement of bone in which spicules of immature bone are developed. The disease is progressive and not self-limited, as bones are never restored to their normal state. In older conditions the progress of the lesions seems to cease and the disease becomes static. There is no known curative therapy. Such complications as fractures require surgical treatment, but elective surgical procedures are usually not indicated. Healing is slow and replacement is by the same type of fibrous tissue.

PHYSICAL THERAPY.

The Genetic Effects of Non-Sterilizing Doses of Penetrating Irradiation.

F. ELLIS (*British Journal of Radiology*, January, 1948) states that non-sterilizing doses of irradiation which cause no demonstrable harmful effect on the individual may, nevertheless, cause serious changes in the chromosomes of the spermatozoa or ova resulting in various types of disability in subsequent generations. It is agreed that: (i) irradiation changes the hereditary materials, no matter how small the dose may be; (ii) the effects thereby produced are all cumulative with increasing dose, being simply additive for some types of change, but increasing geometrically for others; (iii) these changes are almost entirely harmful and therefore undesirable. This information has been gained from the study of organisms other than man. It is therefore necessary to decide how far the findings apply to man and what dose is permissible to individuals and to the population as a whole. Genetic effects of irradiation have been observed in all species tested, and it cannot be doubted that man will show the same hereditary changes. These are of two types. The first is gross change in the structure of the chromosomes as seen under the microscope. The other change is invisible microscopically and is referred to as a mutation of the individual genes themselves. The frequency of gene mutation is directly proportional to the dose received and is independent of the rate at which the dose is received. Structural change on the other hand goes up geometrically with dose, and varies with the rate of application. These types of change occur spontaneously as rarities in all species. The effect of irradiation is not to produce novel types, but to increase the frequency with which changes occur. By experiments on Drosophila sperm it is found that a dose of 50*r* to 100*r* per individual doubles the rate of spontaneous mutation. Conditions such as Friedreich's ataxia, hæmophilia, progressive muscular atrophy and indeed any known hereditary abnormality may follow irradiation. Hereditary changes are sometimes dominant, but more commonly are recessive. Individuals who have a recessive gene of this type transmit it to their offspring so that it is not lost from the population but spreads. From the point of view of man recessive mutants will come to light only slowly, because to do so they must spread sufficiently widely through the population for the individuals, normal in character but carrying the mutant, to marry. Each child of such a marriage has a quarter chance of displaying the effect. If it is assumed by analogy with Drosophila that 50*r* per individual to the gonads before or during active sexual life doubles the spontaneous mutation rate, it can be calculated that a population of 45,000,000 must receive a total of 90,000,000*r* per year. The following lines of investigation are suggested. (i) An investigation might be aimed at assessing the amount of irradiation received by the population and likely to produce genetic effects. This involves: (*a*) workers in medical irradiation; (*b*) workers in irradiation in industry; (*c*) patients receiving X-ray treatment who are within childbearing age and who do not receive sterilizing doses to the gonads; (*d*) patients who are within the childbearing age having X-ray photographs taken (including mass radiography). In a radiological investigation of a pregnancy both the mother and the fœtus receive a dose of at least 1*r* at the gonads. This is a dose of 2*r* to the population. The dose in the case of the fœtus might be larger, depending on its position. (ii) Large-scale experiments might be made to determine genetic effects on mice through several generations. (iii) The rate of diffusion of mutation in the total population might be determined. It is possible that evidence on this point might be available in the relatively small and closed community to which the Schneeberg miners in Czechoslovakia belong. (iv) The life-cycle of the sperm might be determined from the spermatogonial stage to its elimination. The author suggests that in pelvic radiography of males the scrotum should be protected and that in the light of present knowledge non-sterilizing doses should not be given to the ovary, for example, for dysmenorrhœa or sterility, without very careful consideration.

Irradiation of Gastric Cancer.

C. CRANSTON FAIRCHILD AND ALAN SHORTER (*British Journal of Radiology*, December, 1947) state that some 80% of all gastric cancers are beyond any hope of cure by surgery when first seen, hence many other forms of treatment including irradiation have been tried, without striking success. External irradiation fails owing to the deep situation of the tumour and its close relation to other vital organs, to the high radio-resistance of the gastric cancer cells, possibly increased by infection, and to movement of the tumour which makes accurate centring of the X-ray beam difficult. Contact therapy with the Chaoul tube covers only a small area (two centimetres circle) in each field with little penetration at low voltages; bulky tumours could not be destroyed by single surface doses at one operation, but need repeated exposures which can be made only through a pouch or fistula formation; again, localized irradiation would have little or no effect on glandular or local spread. Radon seed implantation presents the difficulty of obtaining uniform and adequate dosage when this is carried out at operation from either the serous or mucous surface or through the œsophagoscope. There are also dangers of hæmorrhage and infection. Intracavitary irradiation with the five-way pack, as described by Livingston and Pack (in 1941), has, it is claimed, the advantages of easy application, fractionation of dosage, freedom from danger of infection and hæmorrhage and no interference with food intake. It would not appear to give an adequate dose to all parts of the tumour, but combined with direct irradiation it might be used to supplement the dose reaching the centre of large tumours. In 1944 the authors began to work out a technique for the direct irradiation of gastric cancers, exposed temporarily at operation. The advantages of the method are that more accurate information about the size, position and extent of the primary lesion and any spread can be obtained by exploration than by any other method—biopsy specimens can be obtained, and an accurate and effective dose of irradiation of high intensity can be given directly to the tumour and field of local spread, without the irradiation of a large volume of normal tissue which is unavoidable with irradiation from the skin surface. Other advantages are that the skin is left practically intact so that further irradiation can be given later if necessary, and that various operations to relieve obstruction can be performed before the irradiation at the same or an earlier laparotomy. The surgical approach may be in one or two stages. In cases in which there is cardiac or pyloric obstruction a preliminary gastrostomy or even jejunostomy may be carried out. The incision used may be a mid-line, an angular abdominothoracic, or an oblique abdominothoracic incision. Two Metropolitan Vickers tubes, 250 kilovolt type, were used with irradiation, having a half-value layer of 1·7 millimetres of copper—the intensity rate 1000*r* per minute from each tube. Two tubes are required, one below the table irradiating the tumour through the skin of the back and one above the table giving the direct irradiation. The authors are varying the tumour dose in an endeavour to find the optimal dose. The dosage now used is 1300*r* surface dose from the under-couch tube and 1600*r* directly to the lesion from above—a minimum tumour dose of 1300*r*. There has been remarkably little irradiation reaction, and that occurs about seven to ten days after the operation. The authors report that fifteen patients were treated by direct irradiation, of whom seven were given palliative treatment only. Of the remaining eight, one man survived for two years, being free from symptoms the greater part of that time. A complete record of the patients treated is given.

Medical Societies.

THE AUSTRALASIAN ASSOCIATION OF PSYCHIATRISTS.

A MEETING of the Australasian Association of Psychiatrists was held at Sydney on October 22 and 23, 1947, DR. H. F. MAUDSLEY, the President, in the chair.

Some Ideals for a Psychiatric Service.

DR. H. F. MAUDSLEY delivered the presidential address entitled "Some Ideals for a Psychiatric Service" (see page 581).

Alcoholics Anonymous.

DR. S. J. MINOGUE read a paper entitled "Alcoholics Anonymous" (see page 586).

Statements were made as follows by two members of Alcoholics Anonymous.

First Statement.

During the year 1917, whilst serving an apprenticeship in pharmacy, I began drinking in a very casual way once a week with a reliever who was an addict and still is and who used to make it the usual practice after work was finished to adjourn to the local for a pint or two; although I had no liking for it at the time. It was not until some years later, when I was working at a public institution, that the habit became more pronounced; I became quite an expert on the various flavours of German beers, wines and Scotch whiskies through association with a buyer who had spent most of his life on the islands and was rarely strictly sober. His reason for drinking was for business purposes; he even procured Chinese whisky for the purpose. As I had my own business, these opportunities for drinking did not exist for a time, until some years later, when dances and parties came into line; these often lasted into the small hours of the morning with the resultant desire for a pick-me-up the next morning and invariably a few more through the day. It was at this time it came to dawn on me that it was becoming an obsession and something must be done about it, so I resolved to sign the pledge for twelve months. On completion the habit became worse than ever, creating fear, anxiety and inferiority slowly, but surely. After many traffic fines and summonses and warnings from the police, things gradually became worse. After a serious bout of lung trouble a change of climate was ordered by the physician, so a trip overseas was undertaken with no improvement. Then the depression hit us and this made things worse, although I was still in business.

I married in 1931 and had periodic spells of sobriety until we purchased another business, and I remained sober for some two years; then the old habit started again with upsetting consequences and remained so for many years, until we disposed of the business and kept out of pharmacy for six months. Then we made another start in another locality with more disastrous results than ever. I was depending on whisky to keep going and running foul with the police whilst there and becoming known to them as a general nuisance, with the result that I was arrested on the slightest provocation for drunkenness; this happened on as many as six occasions.

Circumstances became so desperate that something had to be done. Doctors could do nothing for me, so I interviewed Dr. Lawrence at Broughton Hall. He recommended three months' treatment and I agreed, but remained there fourteen days, coming out somewhat physically fit, but having had no treatment, refusing shock treatment after noticing the after-effects of it. Three or four weeks elapsed; again I clashed with the law, until I could see no other way out but shutting myself up in an institution of some sort as Callan Park or Gladesville. Hence I was desperate. All through the years these periodic bouts brought about a bitter estrangement with my wife, family and relations, until my wife became desperate and dispairing, and threatened to leave me to my fate, a dismal picture indeed.

One day she saw an announcement of Alcoholics Anonymous in the paper and immediately contacted them and went on her own to two or three meetings. We were apart at the time, so I did not know what was going on. I was still up to my old habit, far from reassured, until the anniversary of our wedding came round and I determined to return home and take the consequences. This was done. Being very desperate and remorseful, I was willing to agree to anything, which I did, and accompanied my wife to an Alcoholics Anonymous meeting with a feeling of doubt, curiosity and scepticism, and after a few meetings immediately perceived a different outlook on the habit of drinking, thanks to Dr. Minogue and other members of Alcoholics Anonymous. Meeting and mixing with others who were similarly affected helped me to overcome that habit which had me in chains, and I have remained dry for two years now, thus giving us a true meaning of life and what we exist for, thus presenting to us a love, peace and harmony that no words can describe; the past a definite state of darkness, the present an everlasting joy in everything and everyone around us, giving us a stability of character, confidence, and a general feeling of well-being and goodwill. This was brought about by the fellowship of Alcoholics Anonymous, helping others to overcome similar troubles and worries, and adopting a strictly Christian attitude in all our affairs, whether in pleasure or in business, which demands honesty, tolerance and sincerity in our outlook towards life. And so in closing I would like to recommend an attitude of open-mindedness to this philosophy of life to all similarly affected.

Second Statement.

From a very early age I can remember being of a nervous disposition, self-conscious, extremely sensitive and prone to feelings of high elation, usually succeeded by fits of depression. I gradually acquired knowledge of the evils of alcohol from my father. He was not a drinker himself, but several of his close relatives and intimate friends were definitely of alcoholic disposition, and he felt that timely warnings were needed. These kindly words of advice served to create in my mind a horror of alcohol in any shape or form. At the age of seventeen I was shy and timid without the slightest bit of self-assurance. I began work as a law clerk in the office of a solicitor. I found myself breaking out into a cold sweat each time I had to face people. My life was a self-centred miserable existence. Then I began to drink.

The feeling of ecstasy experienced as a result of those first couple of drinks is difficult to explain. I can only say that all my troubles, real and imaginary, disappeared as if by magic. I had at last found something that had the glorious power of easing the tension of mind and body, and of giving complete relaxation. I had in a moment forgotten all the ominous warnings. I felt sure there must have been a mistake somewhere. There could be no wrong, surely, in anything that could give such instantaneous relief and make a person act more naturally, or so I thought. Needless to say I became a devotee of Madame Alcohol. However, in order that my dad might not have any misgivings, I kept my drinking habits to myself. For some years I managed to drink quite freely without much after effect. I always had a few more than most of the boys, and always, when they wanted to call it off, I wanted to continue drinking. Most of the drinkers I met became tired at some stage and desired rest. With each drink I took my mind became more active. Then I arrived at the blackout period. I would drink until my memory failed, but my body would still function. I have been told on many occasions that my drinking has continued sometimes for hours after my mind has shut off registering. Coincidental with the blackouts, my morning reviver made my acquaintance. I think this was largely due to the fact that the blank space in my mind of the night before caused a terrific amount of worry. The only remedy for this that I knew I adopted. I ceased my studies. I regarded study as a waste of time. I found more pleasurable pursuits were offering in saloon bars. At the age of twenty-seven I think I had developed what I might describe as alcoholic neurosis. Until this time I think that I could have given up drink of my own free will, but since then I know that I have developed alcoholism. By this time I had bought a car necessary in the position I was holding. It became my regular practice to call at an hotel first thing every morning on my way to work to have a few before facing people in at the office. I was caught up in a nice bender about this time, and ended up in the police court for driving under the influence. A couple of years later I joined the Australian Imperial Force. Strange to say my drinking did not improve after I had joined. It deteriorated, especially when I became an inmate of the officers' mess. Underneath my alcoholically developed arrogant manner, I still was very keenly conscious of great inferiority. I could not do without for a moment now, and I was drinking night and day. My mornings began with two bottles of stout on waking, I would then shower, dress, and hasten to the mess before anyone else, where the sergeant would dish me up three or four double Scotches and a schooner or two of beer. Each night practically I drank myself into a blackout.

during my last weeks in Australia before sailing to Malaya. After a short time there I was paraded before the general officer commanding charged with being drunk while on duty, which was all the time. With the fall of Singapore I swore off drink for three and a half years. However, I managed to find a few undestroyed bottles of whisky and gin several days after the capitulation, and I had my last blackout until I landed home in 101 Australian General Hospital, Herne Bay, in November, 1945. I was worse than ever, and of my last month of inebriety I can remember almost nothing. I booked in at a mental home for a few days to try and stop drinking. It had ceased to be a pleasure and I desperately wanted to quit. At the institution I learnt about Alcoholics Anonymous and I became a member, and, with the exception of one slip, I have been leading a life completely free from alcohol. For the first time as long as I can remember I have gained perfect peace of mind, my appetite has improved, I have gained weight, I sleep well. Nothing in this world or the next worries me now. I have ceased to think of or about myself, except that I am useful as a medium of helping to get well other alcoholics. The whole secret of the miracle, as I can see it, is the fact that I have been honest in realizing that alcohol had me beaten, and, knowing that I was unable to do anything about it, I accepted the advice of Alcoholics Anonymous to seek a greater Power to help me. The adoption of this belief has enabled me to free myself from all the responsibilities and worries that have been the source of my drinking. Also by helping other alcoholics whenever possible, I am constantly being reminded of the misery I escaped. I gain also a sense of inner tranquillity. My war neurosis condition has disappeared, or at least is dormant. Human emotions to which previously I was naturally prone have disappeared. These include anger, resentment, hate, jealousy, irritability, nervousness, and many others. The change came gradually. After my last dehydration I began studying the programme laid down by Alcoholics Anonymous, and endeavoured to carry it out to the best of my ability. It has taken about six months. I would like to say that I am definitely not fanatical with regard to religion, but I have found that the greater Power to which I have turned for help has lifted me right out of my self-pitiable state.

Discussion.

PROFESSOR J. BOSTOCK said that it was necessary for sufferers to keep constantly in mind the degrading effects of alcohol; Alcoholics Anonymous brought about this "conditioning" by constantly associating members with new cases of alcoholics in the stage of degradation. He wished to ask whether Alcoholics Anonymous therapy could be applied to women as well as to men.

Dr. Minogue replied that women proved more difficult to treat than men, but Alcoholics Anonymous had about a dozen women members and hoped to establish a women's branch before long.

DR. G. ROSS referred to the frequent absconding of inebriates from mental hospitals when given latitude. He would like to ask (i) if the principles of Alcoholics Anonymous could be applied to alcoholics committed to mental hospitals; (ii) if complete abstention from alcohol was imperative, or if the alcoholic could be educated to drink moderately; (iii) if he as an abstainer could treat such patients adequately.

Dr. Minogue, in reply, said that alcoholics were extraordinarily cunning and plausible in excuses and evasions. Alcoholics in mental hospitals should be treated, firstly, by trusting them and giving them opportunity to justify that trust, and, secondly, if they abused the trust, by enforced detention. He would sooner trust an alcoholic, and be deceived, than not trust him. That was the reverse of usual mental hospital policy. He considered that complete abstention was necessary. One drink was too many: one thousand not enough. The influence of the therapist was very largely dependent on his having experienced, to some extent at least, the experience of the alcoholic. No branch could be successfully started by a non-alcoholic; the failure of a Brisbane branch some time ago was probably due to that cause.

DR. GREY EWAN said that deprivation of alcohol, removal from mental conflict, and attention to physical factors, such as avitaminosis and debility, all helped the alcoholic who was committed to a mental hospital. Many such were demented to some degree and therefore not susceptible to Alcoholics Anonymous therapy. He described a case in which the patient was rigidly shielded from alcohol by his mother, even to the extent of prohibiting any tincture in medicine. At the age of fifty years he was advised by a physician to take a glass of claret for some indigestion; within two years the patient had run the full gamut of alcoholism, and died from its effects. Dr. Ewan's theory was that some people were born with a neural pattern allergic to alcohol, or possibly with some defect of liver function, which intensified the toxic effect of alcohol.

Dr. Minogue agreed with Dr. Ewan that some alcoholics were born and not made. Many alcoholics had a higher intellect than average, but were more susceptible to alcohol.

DR. J. F. WILLIAMS agreed that only one who had shared in some degree the experience of the patient could be a successful therapist. Regarding Dr. Ewan's case and his theory of a vulnerable neural pattern, Dr. Williams considered that other causes, of a psychological nature, probably contributed, such as the effect of slipping from a life-long standard.

DR. D. ARNOTT said that improvement for the alcoholic meant a completely changed defence, and was bound up with philosophy, mental attitudes, and the canalization of life into a healthy groove; Alcoholics Anonymous provided that proper defence against stresses of environment.

DR. O. LATHAM stressed the necessity for sympathy and understanding in these cases. He quoted a prominent physician who had said that he had no sympathy with drinkers. Dr. Latham said that such an attitude did no credit to the profession.

DR. E. T. HILLIARD said that he was reminded of mental hospital inebriates whose committal and often confession had helped. There were many classes of alcoholics, including many defectives and inferior personalities unable to stand up to life's stresses. Dr. Hilliard quoted a case of sexual maladjustment and consequent flight to alcohol. The patient sought voluntary treatment in a mental hospital, made "open confession", and had remained well ever since. He asked if Alcoholics Anonymous had had any success with sexually maladjusted persons.

Dr. Minogue, in reply, explained that one must distinguish between alcoholism as a symptom and inebriety. If one could readjust an alcoholic's outlook on his problems, he would give up alcohol. That applied also if the problems included sexual maladjustment. True inebriates were born and not made. Such a man often preferred to drink alone, was seldom sexually inclined, and drank because his system could not function properly without alcohol. Some men who had been "steady drinkers" for years "lost control" of their drinking, for some unknown reason, between the ages of thirty-five and forty years. Dr. Minogue stressed the necessity for humility, as, if the well-meaning therapist "talked down" to the alcoholic, he merely aroused resentment.

DR. A. STOLLER said that the alcoholic showed childish and neurotic traits, and those were often associated with unconscious factors connected with experiences of infancy and childhood. Psychiatrists should study closely persons who responded to Alcoholics Anonymous's methods and persons who did not respond, and they should try to define the differences between those groups. They should not be satisfied with cures by spiritual experience, but should, in addition, try to collect data for scientific study of the differences between different types of alcoholics.

Psychoanalysis and Other Forms of Psychotherapy.

DR. R. C. WINN read a paper entitled "Psychoanalysis and Other Forms of Psychotherapy" (see page 588).

Why Australia Needs the Psychiatrist.

PROFESSOR J. BOSTOCK read a paper entitled "Why Australia Needs the Psychiatrist". This is published in expanded form under the title "Individual or Individuum: A Survey of Totalitarian and Termite Communities" on page 593.

Discussion.

DR. H. F. MAUDSLEY, from the chair, thanked Dr. Winn and Professor Bostock, and remarked that their eloquence was admired by all; the symbolic ideas expressed by Dr. Winn would make all think.

DR. H. M. SOUTHWOOD gave a summary of Dr. Winn's paper as he himself was interested in the same sphere of work. He discussed the misconceptions of psycho-analysis and remarked on how vague the methods frequently appeared in literature; he felt that steps must be taken to make psycho-analysis more definite. He touched upon the two main principles of psycho-analysis, namely, analysis and suggestion, and recapitulated Dr. Winn's argument that the analyst represented the parent, one or the other or even both, as the patient's difficulty generally started in infancy.

DR. J. BOSTOCK mentioned that he had heard of the carrying out of psycho-analysis by post and inquired if that was possible.

DR. R. C. WINN replied that suggestion by post could be acceptable to patients.

DR. C. H. SWANTON said that he was somewhat depressed by the idea of obsessional neurosis as envisioned by Dr. Bostock and still more depressed to hear from Dr. Winn that the obsessional neuroses were impervious to the highest form of psycho-analysis.

DR. J. A. L. WALLACE inquired whether psycho-analysis could be applied to Dr. Minogue's alcoholics.

DR. B. F. R. STAFFORD thanked both speakers for their papers.

Dr. Maudsley again thanked both speakers and, in conclusion, expressed his indebtedness to the New South Wales section of the association for their programme.

Clinical Meetings.

A demonstration on encephalography was held at the Royal Prince Alfred Hospital, Sydney, and a series of neurological patients were presented at Broughton Hall Psychiatric Clinic, Leichhardt.

Post-Graduate Work.

THE POST-GRADUATE COMMITTEE IN MEDICINE IN THE UNIVERSITY OF SYDNEY.

COURSE FOR DIPLOMA IN ANÆSTHESIA.

THE Post-Graduate Committee in Medicine in the University of Sydney announces that a course suitable for candidates for the Diploma in Anæsthesia will begin in Sydney on June 7, 1948, the fee for which is £31 10s. Sessions will be held in the afternoons only and the course will conclude on November 19. Those desirous of enrolling are requested to make application to the Course Secretary not later than May 17.

COURSE FOR DIPLOMA IN DERMATOLOGY.

A course suitable for candidates for Part I of the Diploma in Dermatology will begin on June 15 and continue for a period of three months. This will be followed in September by a course for Part II of six months' duration. The total fees for the courses for Parts I and II are £52 10s. Separate fees are Part I (£21) and Part II (£36 5s.). Early application is essential. Applications should be in the hands of the Course Secretary not later than May 24.

COURSE IN ADVANCED MEDICINE.

A twelve weeks' course in advanced medicine suitable for M.R.A.C.P. candidates will begin on June 15. All sessions will take place in the afternoons only, the total fee being £31 10s. Application for enrolment to attend the whole or portions of this course should be made to the Course Secretary not later than May 24.

Correspondence.

STANDARDS AT THE UNIVERSITY OF SYDNEY MEDICAL SCHOOL.

SIR: The question of overcrowding of students at the University of Sydney was not raised by me in my letter of March 8, 1948. The objection taken—and unquestionably justifiably so, as a graduate of the University of Sydney—was because of two statements published in the Sydney *Daily Telegraph* on March 3 and 5 last (quoted hereunder).

> Melbourne. March 2, 1948. Sir Alan Newton said yesterday that Sydney University was turning out "half-baked doctors". Sir Alan Newton, who is a leading Melbourne surgeon, was addressing the Melbourne University Council. He said: "We would be doing a great injury to the public by turning out half-baked doctors here. If the Melbourne University admits more students than it can cater for, medical education standards will suffer. What is happening in Sydney is a very real danger."
>
> Sir Alan Newton said to-day that his remarks were not an attack on the Sydney University or its faculty. "I used Sydney University as an awful example", he added. "Teachers from Sydney have told me the medical school is overcrowded. I understand the University cannot legally turn away a student. The remedy is a matter for the New South Wales Government."
>
> Sydney. March 5, 1948. The President of the Medical Board (Dr. H. R. G. Poate) said yesterday: "I have foreseen these conditions for the past five years—but without restriction of medical school enrolments it is impossible to do anything about it. The Medical Board last year registered a record number of new doctors. Because of inadequate training, due to crowded schools, the quality of the new general practitioners registered was on the poor side. I agree completely with Sir Alan Newton, the Melbourne surgeon, that doctors are coming out of Sydney University 'half-baked'. The Faculty of Medicine has lost its place as one of the leading medical schools in the world. More buildings would not solve the problem of overcrowding", said Dr. Poate. "The problem is deeper", he added. "There are not enough patients in hospitals, subjects for dissection, or teachers. In the old days one student had three to four patients to look after. To-day there are ten students to each patient. Thirty or forty students to-day share a subject for dissection where in the old days there were eight. Many years ago Sydney University had a high reputation for the excellence of the doctors it turned out. To-day the products of the University are very, very average. The only solution is to alter the regulations so as to limit the number of students."

The Chancellor of Sydney University, Sir Charles Blackburn, has been reported in the same newspaper as stating the following:

> May 16, 1948. The Chancellor of the Sydney University (Sir Charles Blackburn) yesterday denied that the University was turning out "half-baked medical students". Sir Charles was speaking at the inauguration of the Clinical School for medical undergraduates and the physiotherapy training school at the Royal North Shore Hospital. "I can assure all medical students and students of other faculties that when they leave the University they won't be half-baked but fully baked", Sir Charles said.

If there is overcrowding in universities there are remedies other than quotas and controls, which every supple-minded person is trying to eradicate today from the social life of Australia. In the meantime one still gains the impression that the standards today of the teaching at, and the products of, the University of Sydney still occupy as high, if not higher, a position than in the past and will continue to do so.

Yours, etc.,

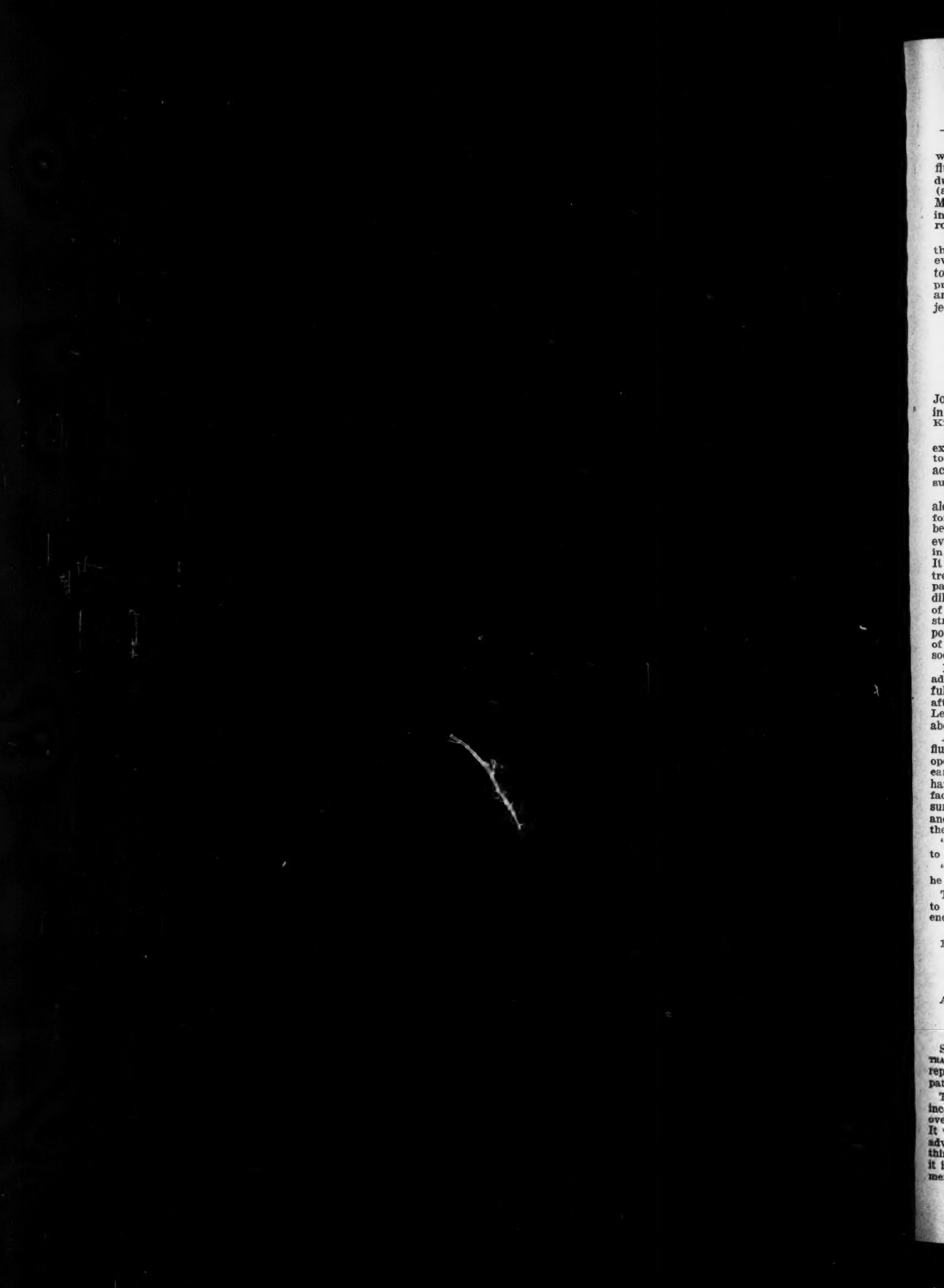
HOWARD BULLOCK.

Rolna,
Macquarie Street,
Sydney.
April 19, 1948.

A BASIC ROUTINE FOR POST-OPERATIVE TREATMENT AFTER LAPAROTOMY.

SIR: I cannot quite agree with Mr. Doyle when he says that the basis of his routine may not be correct. Rather do I believe that the greater part of it is certainly correct, and a lesser part certainly incorrect. The fact that rectal injections disturb the peritoneal region which is usually most inflamed, and that morphine is sometimes needed to make the treatment tolerable, shows that there is something wrong with this part of his routine. On the other hand, controlled sipping of water does not have these disadvantages. Nor does it cause air swallowing, vomiting and paralytic ileus. To suggest its causal relationship with these phenomena is no better reasoning than that of the patient with gastric carcinoma who attributes his indigestion to that feed of mushrooms which he had some weeks ago.

Mr. Doyle reports a considerable reduction of "gas pains" in his patients. How has he achieved this? There are at least a dozen series of controlled observations by different observers in different clinics (some were quoted in my paper in this journal, April 26, 1947), all of which go to show that "gas pains" are mostly due to irregular contractions of the intestine, caused by irritants, such as castor oil, soap or turps. The "gas pains" have nothing to do with gas. Nor can they have anything to do with sips of water, because, in any case, large quantities of fluid are poured into the upper part of the alimentary tract, as can easily be learnt by observing, in the post-operative period, the fluid



which comes from a tube in the common bile duct or the fluid which may be aspirated from an indwelling gastro-duodenal tube. The reduction in the incidence of "gas pains" (and incidentally the disappearance of "paralytic ileus") in Mr. Doyle's patients is probably due to his care in avoiding intestinal irritants and not to his choice of the posterior route for the giving of water.

It is well to distinguish the essential principle (rest for the injured and inflamed part) from the non-essential or even harmful details of any post-operative *régime*. Failure to do this has led to the contradiction and chaos which prevail in this subject, confuse the student and practitioner and make necessary the repeated contributions on the subject, such as Mr. Doyle's and mine.

Yours, etc.,
V. J. KINSELLA.

235, Macquarie Street,
Sydney,
April 20, 1948.

SIR: It is stimulating to see Mr. Leo Doyle (THE MEDICAL JOURNAL OF AUSTRALIA, April 17, 1948) standing to his guns in face of the forceful attack made by an adversary of Mr. Kinsella's calibre.

Mr. Kinsella has done so much, and no doubt often against exasperating opposition from dyed-in-the-wool conservatives, to "blow holes" through the stubborn armour plate of long-accepted routine and ruthless surgical procedure, and with such success, that one must respect his opinions.

On the other hand only those who have gone further along the warpath in this matter than Mr. Kinsella, and for one I refer to Mr. Doyle, can know just how much better Mr. Doyle's method is. No amount of theory can evade the fact that complete restriction of fluids by mouth in the immediate post-operative period is a *sine qua non*. It is easily put to proof: compare two series of cases treated by each method. The comfort experienced by the patient, the absolute absence of such sequelæ as acute dilatation of the stomach and paralytic ileus, to say nothing of "gas" pains being notoriously things of the past, are so striking if one forbids fluids by mouth in the immediate post-operative stage that one cannot deny the inevitability of this becoming the accepted routine by all surgeons sooner or later.

If one breaks a limb or injures a heart every doctor will advise "rest" as a preeminent necessity. Why then forcefully stimulate a disturbed alimentary tract immediately after an abdominal operation? Frankly I do not know. Let the bowel rest; the patient will not regret or complain about it, and the surgeon will sleep better!

At one Sydney hospital it is the routine to "push the fluids" immediately the patient "comes round" from the operation. Solider nourishment is encouraged at the earliest possible moment "to strengthen the patient". I have a vivid recollection of the pained expression on the face of one patient when he described to me how his surgeon came to see him soon after the anæsthetic wore off and cheerfully exclaimed: "Well, old man, have you got the wind yet?"

"Not yet", replied the patient apprehensively, thinking to himself that surely he had been through enough.

"You will!" the surgeon breezily consoled my friend as he hurriedly swept out through the ward door.

Twenty minutes later the patient was given and urged to "get down" a cup of tea. He got the "gas" pains, sure enough. The surgeon was right! And wrong!

Yours, etc.,
RICHARD T. KENNEDY.

175, Macquarie Street,
Sydney,
Undated.

ANNE MACKENZIE ORATION: HUNTER'S ADVICE TO JENNER.

SIR: In a recent issue of THE MEDICAL JOURNAL OF AUSTRALIA (Volume I, 1948, page 359) a writer says that Hunter replied to an inquiry by Jenner: "Do not think, try, be patient, be accurate."

This form of the quotation is probably, almost certainly, incorrect; "think", as here used, suggests "consider, turn over in your mind", rather than "conjecture, guess, surmise". It was against the latter, not the former, that John Hunter advised. It is almost certain that his reply was, "But why think! Why not try the experiment!";[1] in this exhortation it is clear that he was advising, not against the exercise of mental judgement, but against idle speculation.

It is sad that the repute of a wise and thoughtful man should be lowered by the repetition of a false, though attractive, story.

Yours, etc.,
GUY GRIFFITHS.

131, Macquarie Street,
Sydney,
April 17, 1948.

Reference.

(1) Baron: "Life of Edward Jenner", Volume I, page 33.

THE PHARMACEUTICAL BENEFITS ACT.

The Editor,
THE MEDICAL JOURNAL OF AUSTRALIA.

Dear Sir,

The Council of the New South Wales Branch would be grateful if you could publish the attached letter received from the Friendly Societies Association of New South Wales.

Yours, etc.,
J. G. HUNTER,
Medical Secretary.

May 3, 1948.

April 27, 1948.

The Medical Secretary,
British Medical Association,
135, Macquarie Street,
Sydney.

Dear Dr. Hunter,

I refer to the article appearing in *The Sydney Morning Herald* of even date headed "Defence of Medical Formulary". In that article Mr. F. G. Bailey, Federal Secretary of the Friendly Societies Dispensaries and Pharmacists Association, made a statement with respect to the formulary to be used in the Federal free medicine scheme. It is pointed out that in making this statement Mr. Bailey does not express the opinion of the Executive of this Association, nor does he speak on behalf of the Association. Further, this Association has never at any time discussed the formulary to be used under the scheme or the means whereby medicine is to be supplied under the scheme.

It is further stated that friendly societies as organizations are concerned wholly and solely with respect to medicine with the actual supply of medicine and not with the source through which that medicine is supplied, whether it be from dispensaries, chemists or per medium of a national service.

Yours faithfully,
ELWYN A. REES,
Honorary Secretary, Friendly Societies of New South Wales.

Congress Notes.

AUSTRALASIAN MEDICAL CONGRESS (BRITISH MEDICAL ASSOCIATION).

THE Executive Committee of the Sixth Session of the Australasian Medical Congress (British Medical Association) to be held at Perth on August 15 to 21, 1948, has forwarded the following information.

Provisional Programmes for Sections.

A provisional programme for the meeting of sections has been drawn up; the titles of papers to be read are as follows:

Section of Surgery.—"Gall-Bladder Disease"—Presidential Address, "Hæmorrhoids", "Hernia", "Carcinoma of the Colon", "Ulcerative Colitis"—combined with Medicine, "Pulmonary Tuberculosis"—combined with Anæsthesia and Public Health, "Traumatic Unit"—combined with Orthopædics.

Section of Pathology.—"Immunology in Tuberculosis", "The Problem of Immunology in Tuberculosis", "'B.C.G.' Vaccine", "Antibiotics", Possible Papers on Lymph Gland Pathology, Section on Hæmatology, Possible Papers on Liver Pathology.

Section of Neurology and Psychiatry.—"Head Injuries"—Presidential Address, "Child Psychiatry", "Neurological Experiences in the Army", "The Functions of a Mental Hos-

pital Department", "The Medico-Legal Aspect from a Psychiatric Angle of Persistent Offenders".

Section of Dermatology and Industrial Medicine.—"Dermatological Myths and Legends"—Presidential Address, "Industrial Dermatology", Symposium on Eczema and Dermatitis, Clinical Meeting.

Section of Naval, Military and Air Force Medicine and Surgery.—"Coordination of the Medical Services in War"—Presidential Address, "Medical Effects of the Atomic Bomb", "Army Catering: The Fundamental Basis of National War-time Strategy and Fighting Efficiency", Symposium on Eczema and Dermatitis—combined with Dermatology, "The Traumatic Unit"—combined with Orthopædic Surgery, "Amœbiasis"—combined with Public Health.

Section of Orthopædics and Physical Medicine.—"The Traumatic Unit"—Presidential Address, "Common Disorders of the Foot", "Rehabilitation of the Injured", "The Injured Back" ((i) conservative treatment of the injured back, (ii) indications for operation on the injured back, (iii) treatment of the injured back by physical medicine, (iv) the end results of treatment), Presidential Address—combined meeting with Surgery, "Head Injuries"—combined meeting with Surgery, "Treatment of Soft Tissue Injuries"—combined meeting with Surgery, "Tendon Sutures"—combined meeting with Surgery, "The Surgery of Osteoarthritis of the Hip"—combined meeting with Radiology, "Treatment of Osteoarthritis of the Hip by Physical Medicine"—combined meeting with Radiology, "The Treatment of Arthritis by Lactic Acid Injection"—combined meeting with Radiology, "X-Ray Treatment of Osteoarthritis and Other Orthopædic Disorders"—combined meeting with Radiology, "Routine Treatment of Compound Fractures", "Indications and Results of Internal Metallic Fixation".

Obituary.

JACK McFARLANE FONE.

WE regret to announce the death of Dr. Jack McFarlane Fone, which occurred on April 21, 1948, at Carnegie, Victoria.

Nominations and Elections.

THE undermentioned have applied for election as members of the New South Wales Branch of the British Medical Association:

Small, Jean Maude, M.B., B.S., 1943 (Univ. Sydney), 41, Pennant Hills Road, Normanhurst.

Dunlop, Roger John Massie, M.B., 1944 (Univ. Sydney), 10, Wentworth Street, Point Piper.

The undermentioned has applied for election as a member of the Tasmanian Branch of the British Medical Association:

Ralston, Mary, M.B., B.S., 1947 (Univ. Sydney), General Hospital, Launceston.

Research.

THE MARY AND EVELYN BURTON RESEARCH FELLOWSHIP.

THE trustees of the Mary and Evelyn Burton Institute, with the approval of the Committee of Management of the Children's Hospital, Melbourne, have appointed Dr. Reginald Webster to the Mary and Evelyn Burton Research Fellowship and to the curatorship of the Reginald Webster Pathological Museum. Both appointments are in connexion with the Burton Institute. Dr. Webster has been for thirty-four years pathologist of the Children's Hospital, Melbourne, and his writings are well known to readers of THE MEDICAL JOURNAL OF AUSTRALIA. Among Dr. Webster's duties are the following: (*a*) to engage in research, the nature and extent of which will be determined by Dr. Webster himself; (*b*) to develop further the pathological museum which he has built up at the Children's Hospital, and later to instal and maintain it in the new hospital, where it will be known as "The Reginald Webster Museum of Pathology". After a transition period, which will allow for the transfer of Dr. Webster's present duties to another officer or officers, Dr. Webster will have no duties or responsibilities in the hospital other than those pertaining to the fellowship and curatorship. He will, however, be available for consultation as honorary consulting pathologist to the hospital, and he will have access to such clinical and pathological material as he may require for the purposes of research, for the museum or for lectures and demonstrations.

Diary for the Month.

MAY 11.—New South Wales Branch, B.M.A.: Executive and Finance Committee.
MAY 13.—South Australian Branch, B.M.A.: Branch Meeting.
MAY 13.—Victorian Branch, B.M.A.: Organization Subcommittee.
MAY 14.—Queensland Branch, B.M.A.: Council Meeting.
MAY 17.—Victorian Branch, B.M.A.: Finance, House and Library Subcommittee.
MAY 18.—New South Wales Branch, B.M.A.: Medical Politics Committee.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Honorary Secretary, 135, Macquarie Street, Sydney): Australian Natives' Association; Ashfield and District United Friendly Societies' Dispensary; Balmain United Friendly Societies' Dispensary; Leichhardt and Petersham United Friendly Societies' Dispensary; Manchester Unity Medical and Dispensing Institute, Oxford Street, Sydney; North Sydney Friendly Societies' Dispensary Limited; People's Prudential Assurance Company Limited; Phœnix Mutual Provident Society.

Victorian Branch (Honorary Secretary, Medical Society Hall, East Melbourne): Associated Medical Services Limited; all Institutes or Medical Dispensaries; Australian Prudential Association, Proprietary, Limited; Federated Mutual Medical Benefit Society; Mutual National Provident Club; National Provident Association; Hospital or other appointments outside Victoria.

Queensland Branch (Honorary Secretary, B.M.A. House, 225, Wickham Terrace, Brisbane, B.17): Brisbane Associated Friendly Societies' Medical Institute; Bundaberg Medical Institute; Brisbane City Council (Medical Officer of Health). Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

South Australian Branch (Honorary Secretary, 178, North Terrace, Adelaide): All Lodge appointments in South Australia; all Contract Practice appointments in South Australia.

Western Australian Branch (Honorary Secretary, 205, Saint George's Terrace, Perth): Wiluna Hospital; all Contract Practice appointments in Western Australia. All government appointments with the exception of those of the Department of Public Health.

Editorial Notices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

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